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THE PENNSYLVANIA MEDICAL JOURNAL

JANUARY, 1950 - DECEMBER, 1950

REPRESENTING

THE TRANSACTIONS OF THE MEDICAL SOCIETY
OF THE STATE OF PENNSYLVANIA

(VOLUME 53 OF THE JOURNAL)



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Publication Committee

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An Editorial

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Infections of the Newborn
Stewart H. Clifford

The Sex Deviate
Edward E. Mayer

Our New Face
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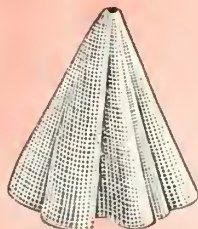
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LETTERS

March of Dimes

GENTLEMEN:

Through the years, summer in the United States always has been marked by outbreaks of infantile paralysis. And every winter we have come to expect a successful fund-raising campaign to meet the needs of those affected.

The March of Dimes campaign, enthusiastically supported by magazines as well as by the press and radio in the past, has always raised enough to take care of the polio situation. In 1949, for example, although fewer than a hundred persons contributed more than a thousand dollars, the money rolled in . . . dimes from the millions, your readers!

However, this summer saw more than outbreaks of polio. There was a widespread, nation-wide epidemic, with more cases than ever before in our history. All resources of the National Foundation for Infantile Paralysis were pressed into service. The organization's epidemic treasury was emptied.

Now the bills for the epidemic's aftermath pile up—bills for the treatment of the crippled, those still in hospitals, those who must be rehabilitated, bills to be paid without curtailing the training of medical personnel and scientific research to find a preventive. But funds to pay all of these bills are lacking. And we have no way of knowing how many more cases there will be next year.

We face a possible crisis in polio that will menace every man, woman, and child in the United States unless, this winter, the March of Dimes takes in more money than ever before. Your readers must know the need. That is why I ask that you call the situation to your readers' attention.

The Editorial Committee of your National Association of Magazine Publishers has endorsed the 1950 March of Dimes. Won't you please remind your readers of the March of Dimes, if you can, somewhere in the issue you expect to circulate during the last two weeks of January, 1950?

BASIL O'CONNOR, *President*,
The National Foundation for
Infantile Paralysis, Inc.,
120 Broadway, New York 5, N. Y.

AMA Membership Assessment

GENTLEMEN:

Enclosed you will find my check for \$25 covering the 1949 AMA membership assessment—my contribution toward the grand effort of keeping us free, individually and collectively, from the quagmire and morass of political control.

_____, M.D.

GENTLEMEN:

At last my AMA assessment is being sent you herewith. I believe strongly in its program despite my delay.

_____, M.D.,
Pennsylvania.

Veterans Loan Fund MSSP

GENTLEMEN:

Enclosed is my check for \$500 repaying the loan granted to me in 1946. I want to express my deepest appreciation for this loan and the way in which it was granted, as it certainly was a great help in getting re-established in practice.

_____, M.D.

A.M.A. WITHDRAWS ACCEPTANCE OF SULFA DRUG

The American Medical Association Council on Pharmacy and Chemistry has withdrawn its acceptance of sulfathiazole and sulfathiazole sodium, according to an announcement in the September 24 *Journal of the American Medical Association*.

"The council recently considered the present status of sulfathiazole," the statement says. "It considered the fact that approximately 18 per cent of patients who receive sulfathiazole develop untoward reactions such as fever, rash, acute leukemia, leukopenia, and other manifestations of toxicity (which compares with about 16 per cent for sulfapyridine, 12 per cent for sulfanilamide, 6 per cent for sulfadiazine, and 7 per cent for sulfamerazine).

"Further question of the need for continuing acceptance of sulfathiazole was raised in view of the fact that less toxic sulfonamide drugs and penicillin and streptomycin are now available. In conformance with its policy of withdrawing acceptance of a toxic drug when a less toxic but equally effective agent becomes available, the council voted to omit sulfathiazole and sulfathiazole sodium from the 1949 edition of *New and Nonofficial Remedies*.

"Further consideration of this subject was precipitated by the fact that there are at present marketed a number of sulfonamide mixtures containing sulfathiazole or sulfathiazole sodium. The council decided that such mixtures involved risk of the danger which led it to omit the drug itself from N. N. R. The council therefore declared mixtures of sulfathiazole or sulfathiazole sodium with other agents unacceptable for inclusion in N. N. R."

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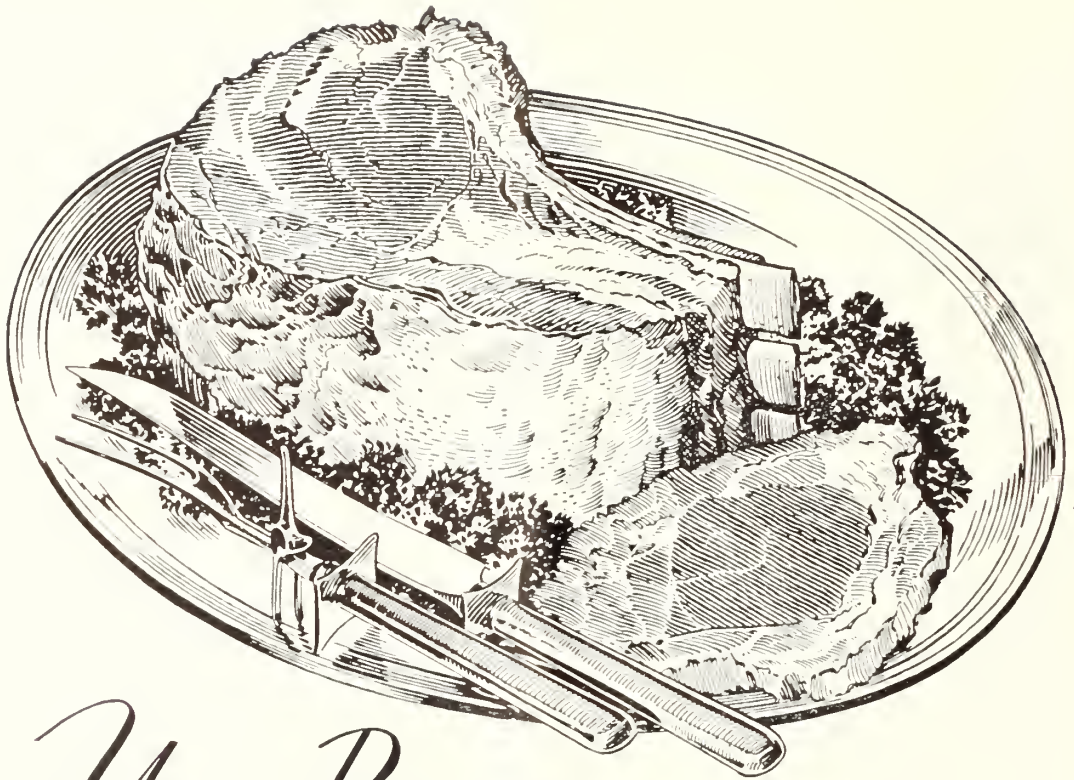
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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

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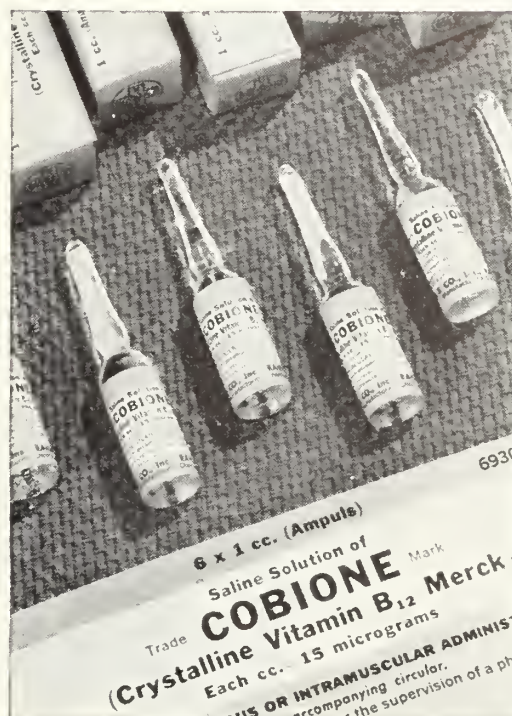
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*COBIONE is the registered trade-mark of Merck & Co., Inc. for its brand of Crystalline Vitamin B₁₂



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a development of
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Dilution: one fluid ounce to one and a half ounces of boiled water for each pound of body weight.

Biolac is available in 13 fluid ounce tins.

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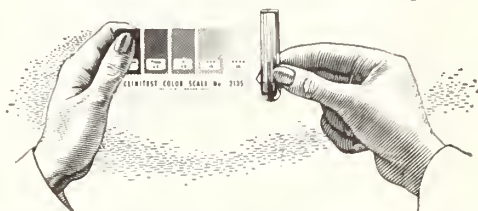
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A well-controlled diabetic is less susceptible to infection and acidosis. The incidence of vascular complications, retinitis, gangrene, and renal intercapillary glomerulosclerosis is reduced with vigorous control. "Too little" is the symbol of inadequate control.



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Selftester to detect  **Urine-sugar**
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*Joslin, E. P., Postgrad. Med., 4:302 (Oct.) 1948;

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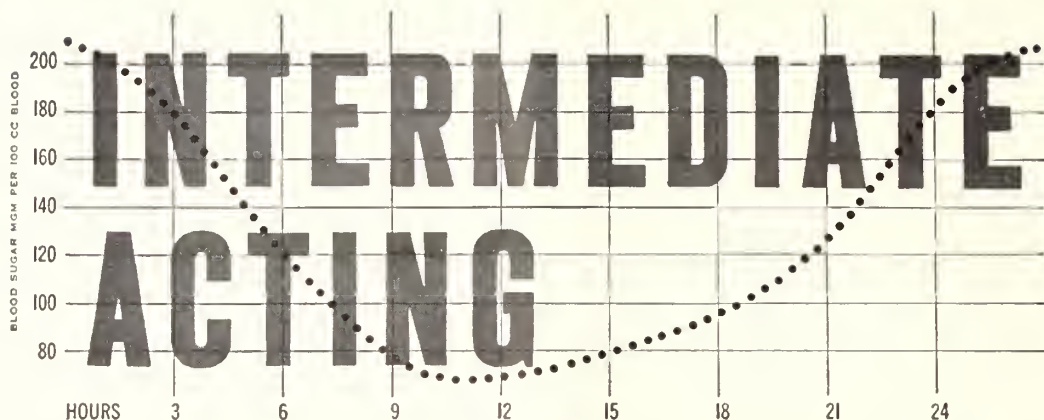
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In 10 cc. vials, U-40 and U-80.

¹ Rohr, J.H., and Colwell, A.R.: Arch. Int. Med. 82:54, 1948.

² ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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THE *Pennsylvania* MEDICAL JOURNAL

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Number 1

Infections of the Newborn and Premature Infant

STEWART H. CLIFFORD, M.D.

Boston, Mass.



INFECTIONS remain an important cause of morbidity and mortality in full-term and premature infants despite available medical knowledge capable of preventing or controlling bacterial disease in newborn nurseries.

The basic principles governing the prevention and control of infections in nurseries for the newborn are few and simple: (1) Block air-borne infections, both that acquired at short range by droplet transmission and that acquired from pathogenic organisms diffusely distributed throughout the air. (2) Block infection acquired from the ingestion of pathogenic organisms contained in food or fluid. (3) Block infection acquired from physical contact between the infant and infected personnel or material.

The problem of infection in nurseries is relatively new since it has only been in recent years that our babies have been delivered in hospitals and collected for care in crowded nurseries. In yesteryears the baby in his own home never was exposed to the hazards of infection confronting

his present-day nursery counterpart. The individual physician attending his patient in the newborn nursery is in a hopeless position insofar as his efforts go to prevent infection due to the innumerable routes of infection in the environment over which he has no control. He must try to put out the fire since it was not in his power to prevent it.

The solution to the problem demands a broad approach along public health lines and involves the coordinated efforts of the doctors, nurses, hospital administrators, and public health officers. The environment in which the newborn finds himself at birth must be made safe.

The primary obligation of the public health department is to protect the public. Every state should have laws requiring the licensing of all maternity homes and hospitals. The health department should require compliance with a definite set of standards, and inspections should be frequent enough to make sure that these standards are being observed. Although all public health departments must have police power, it is very bad public health policy to use this power. Experience has shown that when the health department calls all interested parties into conference, explaining the various parts of its regulations, voluntary—even enthusiastic—cooperation is forthcoming.

It is fortunate that the many health departments and hospitals need not work out, independently, the details of standards and recom-

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 29, 1949.

From the Boston Lying-in Hospital, the Children's and Infants' Hospitals of the Children's Medical Center of Boston, and the Departments of Obstetrics and Pediatrics, Harvard Medical School.

mendations for the hospital care of full-term and premature newborn infants. The American Academy of Pediatrics has recently published a manual on this subject that is available to all.*

The program of the individual hospital to safeguard its newborn from infection centers around the appointment of one physician as the head of the nursery service. This physician should be made personally responsible for the development, maintenance, and enforcement of standards.

Blocking Air-borne Infections

No one with an infection or suspected infection should be permitted in the nursery.

All personnel should in my opinion wear masks, so made that they are effective in preventing droplet infections, unless the infants are kept in enclosed beds or incubators.

Overcrowding of nurseries should be avoided. There should always be at least two feet of space separating all bassinets and an aisle space three feet wide.

For nurseries with limited available space, for isolation nurseries, and for premature-infant nurseries an incubator of the Chapple type may be the solution. In this incubator the infant is surrounded by conditioned fresh air drawn directly from outdoors and is further protected from all droplet infection through being completely enclosed in the incubator.

Chapple¹ reports that recent experience has demonstrated that the air in the nurseries can be sterilized by ultraviolet radiation and by the evaporation of propylene glycol to a strength of 1:5,000,000 in the air (a continuous evaporation of approximately 0.01 cc. of propylene glycol per cubic foot in a still nursery).

The bacterial count in the air can be reduced by the use of an oil film on the floor and by oil-impregnated blankets and linen.

Blocking Infection Acquired Through Food or Fluid

All bottles, caps, and nipples should be thoroughly washed, using a detergent solution. The nipples should be inverted in the cleaning process. Formulas are made using clean but not aseptic technique and formula or fluid placed in

the individual bottles. Nipples and clean caps are then applied, completing the unit assembly.

The units should then be sterilized either by high pressure terminal heating at a temperature of 230 to 232 degrees Fahrenheit (seven pounds pressure) for 10 minutes, or by non-pressure flowing steam at 212 degrees Fahrenheit for not less than 25 minutes and for not more than 30 minutes.

The units are then removed from the sterilizer, allowed to cool at room temperature for one to two hours, and placed in a refrigerator maintained at a temperature of 40 to 45 degrees Fahrenheit until feeding time.

Blocking Infection from Physical Contact Between the Infant and Infected Personnel or Material

Cummings² and his group were able to prevent this type of infection through expert nursing supervision, adequate nursing personnel, infection control among nursery personnel and mothers, carrier control among nurses and mothers, isolation of infected infants, hand technique, sterile supplies, and visitor control.

Epidemic diarrhea of the newborn has become a public health problem only since large numbers of babies have been concentrated in common nurseries. While diarrhea of virus origin does occur, it is in my opinion responsible for relatively few outbreaks. A larger number of diarrhea outbreaks are due to pathogenic organisms that could reach the infant only by the fecal-oral route. However, the vast majority of epidemics of diarrhea are due to gross contamination of the infant with organisms, not ordinarily considered pathogenic, that reach the infant through gross breaks in nursery technique.

All who have been given the grave responsibility of the newborn nurseries in lying-in institutions know that sooner or later, for one reason or another, diarrhea may develop in one or more of their infants. If it develops in one infant, he should be instantly isolated in an isolation nursery until the significance of the situation can be judged. Should two infants from the same nursery have diarrhea, both babies must be isolated and the nursery quarantined until all contacts have been discharged and the nursery cleaned and made ready for new admissions. With the declaration of the quarantine, a mobile nursery should be set up in an available room into which all freshly delivered patients shall

* Standards and Recommendations for Hospital Care of Newborn Infants, Full Term and Premature. American Academy of Pediatrics, Dr. Clifford G. Grulec, Secretary, 636 Church St., Evanston, Ill. Price, 50 cents.

TABLE I

A COMPARISON OF THE DISTRIBUTION OF PREMATURE INFANTS IN VARIOUS WEIGHT GROUPS AT THE BOSTON LYING-IN AND CHILDREN'S HOSPITAL NURSERIES

Birth Weights	Percentage of Prematures in Various Weight Groups 1944-1948	
	Boston Lying-in Hospital	Children's Hospital
0-1000 (0 to 2.3)	6	11
1001-1500 (2.4 to 3.4)	10	29
1501-2000 (3.5 to 4.6)	22	41
2001-2500 (4.7 to 5.8)	62	19

be admitted. If diarrhea develops in three infants from the same nursery, the syndrome of epidemic diarrhea of the newborn is assumed to be present, and the situation instantly reported to the board of health.

Strict adherence to this program may well limit a potential epidemic to one or two cases. The literature stresses the fact that it is disastrous to temporize with this situation.

Should a real outbreak of epidemic diarrhea occur, reported experience insists that the only way to stop the outbreak is to shut down the entire obstetric unit to all admissions until all patients are discharged.

Actual Experience in Preventing and Controlling Infection in a Premature Nursery

For years infection had been a major problem in the Children's Hospital premature nursery. The premature infants admitted to this nursery represent a selected group of cases not comparable to a group of prematures delivered and cared for in the same obstetric unit. The Children's Hospital premature infants are all referred into the nursery from all parts of New England. They arrive at various ages, having been exposed to varying degrees of chilling and exposure to infection. They have been subject to obstetric and pediatric management beyond our control. Compared to the normal incidence of prematures to be expected in various weight

groups, we find that the Children's Hospital nursery has a very high proportion of its infant population in the smaller weight groups (Table I).

The referring doctors and hospitals tend to care for their larger prematures if they are in good condition and, as a result, the Children's Hospital nursery has relatively fewer large prematures, but those that are sent in experience a high mortality rate (Table II).

The situation that particularly distressed us at the Children's Hospital was the fact that we were losing too many babies who had had normal courses for weeks and then sickened, became afflicted with diarrhea, and died (Table III).

Causes of Death in Premature Infants Dying after the First Week of Life at the Children's Hospital Nursery

The records of 57 infants dying in the Children's Hospital premature nursery after the age of seven days have been studied to establish the causes of death. In this group 48 complete post-mortem examinations had been made. Infection was found to be the cause of death in 41 infants and the probable cause of death in an additional seven babies. In two infants death was due to intracranial hemorrhage and in one it was the result of multiple congenital defects. In six in-

TABLE II

A COMPARISON OF PREMATURE INFANT MORTALITY RATES AT THE BOSTON LYING-IN AND CHILDREN'S HOSPITAL NURSERIES

Birth Weights	Premature Infant Mortality in Various Weight Groups (Per Cent)	
	Boston Lying-in Hospital 1944-1948	Children's Hospital 1944-1947
0-1000 (0 to 2.3)	92	97
1001-1500 (2.4 to 3.4)	58	66
1501-2000 (3.5 to 4.6)	13	39
2001-2500 (4.7 to 5.8)	5	31
0-2500 (0 to 5.8)	16	50

TABLE III
PREMATURE INFANT DEATHS AT VARIOUS AGES IN THE CHILDREN'S HOSPITAL NURSERY

<i>Percentage of Premature Infants Dying at Various Ages in Children's Hospital</i>					
<i>Age at Death (Days)</i>	1944	1945	1946	1947	1944-1947
0-7	58	71	81	54	68
8-21	12	11	8	23	13
22-35	12	13	8	16	12
36+	18	5	3	7	7

infants the cause of death could not be definitely established.

Pneumonia, alone or in combination with other infections, was diagnosed at autopsy examination in 41 infants. The examinations revealed pneumonia in 23 infants; pneumonia and purulent otitis media in eight; aspiration (not terminal) pneumonia in eight; and pneumonia and meningitis in two infants.

Other infections discovered at the pathologic examinations were peritonitis in three infants; gastro-enteritis in two; and osteomyelitis in one infant.

The frequency and type of pathogenic organisms, alone or in combination, recovered from these 57 infants are given in Table IV.

Twenty-seven per cent of the admissions in 1944 were infants over 7 days of age (Table V). This situation was recognized as dangerous not only to the individual admitted but also to the other infants in the nursery. As a result it was decided that no infant older than 7 days should be admitted to the premature nursery. Prema-

ture infants older than 7 days of age were henceforth to be cared for on the regular infants' ward. The referring hospitals and physicians gave immediate cooperation once the reasons in back of the regulation were made clear. The incidence of prematures admitted during their first day of life immediately jumped from 59 per cent to over 80 per cent. Very few infants were admitted beyond the 7-day limit requiring care on the ward.

TABLE IV
PATHOGENIC ORGANISMS RECOVERED FROM 57 INFANTS
No. of Cases

<i>B. coli</i>	23
<i>Staphylococcus aureus</i>	13
<i>B. hemolytic streptococcus</i>	9
<i>H. influenzae</i>	3
<i>B. mucosus capsulatus</i>	2
<i>Pneumococcus</i>	1

Relocation and Reconstruction of the Children's Hospital Premature Nursery

At the close of 1945, infection was still as serious a problem as ever in the premature nurs-

TABLE V
THE AGE AT WHICH PREMATURE INFANTS WERE ADMITTED TO THE CHILDREN'S HOSPITAL NURSERY

<i>Percentage of Premature Group Admitted to the Children's Hospital Nursery at Various Ages</i>					
<i>Age (Days)</i>	1944	1945	1946	1947	1948
Newborn	59	81	81	81	84
2-4	9	11	12	17	10
5-7	5	6	7	2	4
8 and over	27	2	0	0	2

ery, in spite of all the effort that had been spent toward its eradication. The situation appeared so desperate to those in authority that the wisdom of attempting to care for premature infants in the environment of a general children's hospital was seriously debated.

The original premature nursery rooms had not been laid out with the problem of controlling infection in mind. One air-conditioned room was on the second floor of the Infants' Hospital, separated from the regular infant patients by one door. The second air-conditioned unit of two rooms was directly below on the first floor, also separated by one door from the infants on that ward. To pass from one part of the premature nursery to another the personnel and patients had to pass through the general ward area. The possibilities for breaks in technique were legion and it was agreed that the premature nursery should be relocated and reconstructed.

In 1946 the premature nursery was concentrated on the second floor and effective physical barriers were constructed to separate the premature infant area from the sick infant ward. The present premature nursery can be entered only through an anteroom where those with the right to enter put on caps and masks, scrub, and put on sterile gowns.

Quarantine Technique for New Admissions

The cubicle system of individual isolation technique had proved to be no barrier to cross-infection in our premature nursery. With the opening of the new nursery in May, 1946, it was decided to isolate each new admission for a preliminary period of from seven to ten days and at the end of this period transfer the child to the common premature ward, providing no sign of infection was present.

To provide this period of individual isolation, four Chapple beds were purchased. These beds provided each infant with a small, completely enclosed chamber into which fresh outdoor air, heated and humidified to individual requirements, was circulated.

This quarantine technique failed to prevent infection from breaking out in the common premature nursery. The failure of this system was attributed to a number of factors. We did not have a sufficient number of individual isolation beds to accommodate all of the admissions for even a seven-day quarantine period. It was frequently necessary to decide on clinical grounds

which of two admissions should be isolated in the one available bed. We still do not know how long the quarantine period should be; for instance, there are those who claim that the incubation period for the virus type of epidemic diarrhea may be thirty days. Even though the patients themselves could be eliminated as sources of infection in the premature ward, they may contract infection from the attending personnel and the food and fluid they are given by mouth.

Individual Isolation Technique

By 1947 we were convinced that the type of individual isolation provided by Chapple's bed protected the baby from the dangers of cross-infection as long as he remained in the unit. Our objective became the acquiring of a sufficient number of those units to provide one for the use of every infant from the moment he enters the nursery until his discharge home. The ladies of the welfare committee of the hospital undertook the providing of this equipment as their special project. We now have the four old-type Chapple beds and eight of the new-type "Isolettes" and have at last achieved the ideal for which we aimed.

Sterilization of the Formula

The untrustworthy pasteurization method of sterilizing the formula was the only technique available until 1948. In 1945 and again in 1947 outbreaks of diarrhea were suspected of having originated from contaminated formula. In the first instance cultures of the different types of formula produced *B. subtilis*, *B. alkaligenes*, *Staphylococcus albus*, and gamma streptococci. Errors in technique were discovered and corrected and what was thought to be adequate controls instituted. By 1947 new breaks in technique had slipped in; for instance, the formula was being processed in bulk quart bottles, the upper third of the formula being above the water line in the bath. Needless to say, processing the formula was placed under even more rigid supervision, but we were amply convinced that no system of sterilizing the formula is safe that depends on the human factor. The dangerous pasteurization technique was replaced in 1948 with a modern system of terminal sterilization using flowing steam at 212 degrees for 25 minutes.

Chemotherapy and Antibiotics

Sulfadiazine and penicillin were used exclusively throughout the entire period of this study;

TABLE VI
COMPARISON OF PREMATURE INFANT MORTALITY RATES
BETWEEN 1944-1947 AND 1948

<i>Premature Infant Mortality in Various Weight Groups in Children's Hospital Nursery</i>		
<i>Birth Weight</i>	<i>1944-1947 (Per Cent)</i>	<i>1948 (Per Cent)</i>
0-1000 (0 to 2.3)	97	74
1001-1500 (2.4 to 3.4)	66	25
1501-2000 (3.5 to 4.6)	39	21
2001-2500 (4.7 to 5.8)	31	46
0-2500 (0 to 5.8)	50	36

however, the principles governing their use have changed drastically. In the early years these drugs were used chiefly as therapeutic agents in the treatment of actual or suspected infection in the individual case. By 1948 their use had become almost exclusively as prophylactic agents in certain types of patients who had been found by past experience to be particularly vulnerable to infection.

Autopsy examinations had shown that the premature infant with even minor degrees of intracranial or anoxic injury was particularly prone to contract infections. The rapidity with which serious infection developed under these conditions was demonstrated by two infants dying on their second day of life. In both babies some intracranial hemorrhage was present, but to such a mild degree that recovery should have ensued. In both babies blood cultures were positive for *B. coli*.

Sulfadiazine and penicillin therapy in the treatment of established bacterial infection in premature infants has been quite disappointing. This statement is particularly true when this infection takes place in an infant already handicapped by birth or anoxic injury.

We now give prophylactic penicillin and sulfadiazine to all premature infants over three days of age on admission to the nursery and to all in-

fants of any age whose admission history leads one to suspect contact with infection or whose examination reveals evidence of possible injury. Since the chief offending organisms are *B. coli* and *Staphylococcus aureus*, we must give both penicillin and sulfadiazine until the exact nature of the infection can be determined.

The foregoing procedures have been responsible for the practical elimination of infection as a problem in the Children's Hospital nursery.

*The Results of Efforts to Prevent and Control
Infection in the Children's Hospital
Premature Nursery*

From 1944 through 1947, 9 per cent of the admissions to the Children's Hospital premature nursery weighed under 1000 grams (2 pounds, 3 ounces) and had a mortality of 97 per cent; in 1948, 20 per cent were in this group and had a mortality of 74 per cent.

From 1944 through 1947, 30 per cent weighed from 1001 to 1500 grams (2-4 to 3-4) with a mortality of 66 per cent; in 1948, 26 per cent were in this group with a mortality of 25 per cent.

From 1944 through 1947, 41 per cent weighed from 1501 to 2000 grams (3-5 to 4-6) with a mortality of 39 per cent; in 1948, 40 per cent were in this group with a mortality of 21 per cent.

From 1944 through 1947, 68 per cent of the deaths took place in the first 7 days of life, 13 per cent between the ages of 8 and 21 days, 12 per cent between 22 and 35 days, while 7 per cent occurred after the age of 36 days; in 1948,

TABLE VII
COMPARISON OF PREMATURE INFANT DEATHS AT
VARIOUS AGES IN THE PERIOD BETWEEN
1944-1947 AND 1948

<i>Percentage of Premature Infants Dying at Various Ages</i>		
<i>Age at Death (Days)</i>	<i>1944-1947</i>	<i>1948</i>
0-7	68	100
8-21	13	0
22-35	12	0
36+	7	0

TABLE VIII
COMPARISON OF INDIVIDUAL TREATMENTS GIVEN IN
THE CHILDREN'S NURSERY IN 1944 VS. 1948

Types of Treatment	Total Number of Treatments	
	1944	1948
Clyses	177	0
Intravenous therapy	110	0
Transfusions or plasma infusions ..	49	0
Number of infants treated	35	0
Total patients	106	94

100 per cent of the deaths took place in the first five days of life.

Perhaps the most dramatic change particularly evident to the house staff has been the reduction in morbidity. The records for 1944 and 1948 have been reviewed and individual treatment given to each infant recorded.

In 1944, with 106 admissions, 35 infants required the following individual treatments: clyses, 177; intravenous therapy, 110; transfusions or plasma infusions, 49.

In 1948, with 94 admissions, not a single infant was given a clysis, intravenous therapy, transfusion, or plasma infusion.

*Summary of Methods to Prevent and Control
Infection in a Premature Nursery*

1. One physician should be made responsible for the premature nursery service.
2. The "Standards and Regulations for the

Hospital Care of Newborn Infants—Full Term and Premature" should be followed religiously.

3. Premature nurseries in obstetric hospitals should not admit patients delivered outside.

4. Premature nurseries in pediatric hospitals should encourage referring hospitals and physicians to send their infants in as soon after birth as possible. No infant older than 7 days of age and no infant with an infection should be admitted to the premature nursery unless equipment providing effective individual isolation is available.

5. The premature nursery should be located as far away from the hospital area caring for sick infants as possible.

6. The premature nursery should be constructed with as many barriers between it and the rest of the hospital as is practical. Entrance to the nursery should be gained through an ante-room.

7. The medical and nursing staff, while caring for premature infants, should be relieved of all duties involving the care of sick patients.

8. Every infant should ideally be kept in his own completely enclosed and air-conditioned unit from admission to discharge.

9. All formulas should be terminally sterilized by either the flowing-steam or steam-under-pressure method.

10. In premature nurseries outside obstetric hospitals all admissions, with the possible exception of perfectly healthy newborns, should be given a prophylactic course of penicillin and sulfadiazine.

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THE SEX DEVIATE

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THE sex deviate, always a public problem, has recently more than ever become a social and health menace. Yet, with the exception of a small group of psychiatrists, physicians have not interested themselves in the sex offender. Impulse or character neurotics, perverts, sex variants or deviates, psychopaths—whatever title is given to them—they are so far removed from the core of medical practice that no active program could be expected to come from the general body of physicians. This is even more true because moral and legal factors are involved, thus making it far from being only a medical problem.

In addition to the usual responsibilities to their patients, physicians should, however, take more interest in this group. The situation is somewhat similar to that which existed at one time with other public health problems. Groups of laymen initiated programs in many fields of sickness and not the medical profession. In this area of the sex deviate, physicians, trained as they are to think objectively and less swayed, therefore, by prejudice and not moved by mass hysteria, should be the leaders in the movement for legislative reforms and a better understanding of our cultural ethos. A physician is, of course, also a citizen and most likely also a parent. So it would seem that he has reason to attempt to better the situation as it exists today. I am aware that physicians and their organizations are averse to assuming leadership in any social planning, and yet the welfare of our social order should be their concern.

The public expects the family doctor to be informed about how to treat a sex deviate just as it expects him to care for the ordinary illnesses of mankind. His patients naturally turn and should turn to him for advice rather than to a lawyer or a police court. Perhaps this can be realized more clearly by recalling the many sex problems which are daily handled by a physician.

The frigid woman, for instance, and the impotent male in the great majority of cases have psychologic situations which are not far removed from those of the homosexual. To put it another way, there are more latent sex deviates than there are active ones. They often seek associations in social groups to cover up their tendency. This is true of some who join a nudist colony. It is not surprising to a psychiatrist to find many voyeurs or exhibitionists in such a group. I have in mind a patient of mine, an only child, whose mother dressed him like Little Lord Fauntleroy. He was the object of ridicule by the other boys of his neighborhood who rejected him and this tended to increase the undue attachment that existed between his mother and himself. Though a neurotic, he became a good citizen, married, and was successful in business. Only his wife and myself knew that he was impotent. A few years ago he was in an automobile accident. As a result of a spinal injury he was paralyzed from the waist down. After he left the hospital, he founded a nudist colony. The accident not only released him from his psychic bondage to his mother but also gave a different slant to his neurotic impotency which had existed previously. For now he had a physical basis for it even though it increased his homosexual tendency.

Sex and its problems is of course not new. The myths and legends of primitive people abound in illustrative examples. In fact, sexual superstitions often influenced the group to such an extent that taboos developed by reason of them. These were also the basis for many religious practices in primitive times. The story of the lives of ancient gods and goddesses reveals how prevalent sex practices were which are offensive to society today. The Old Testament is not an exception. The story of the destruction of the cities of Sodom and Gomorrah, because of the perverted practices of their inhabitants, is well known. The tale goes on to tell how Lot and his wife and their two daughters were saved.

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.

All of you recall how Lot's wife was turned into a pillar of salt because she looked back. It is curious that not only is this a phallic symbol but also that salt was the most precious of all edible things. The ending of Lot's story also has significance. Lot and his two daughters reached a cave. On two successive nights, each daughter in turn plied her father with wine and in his stupor lay with him, so that both conceived and from this unnatural (incestuous) union had a male child.

In Leviticus is found this passage: "If a man also lieth down with mankind as he lieth with a woman, both of them have committed an abomination. They shall surely be put to death." In contrast, about 1500 years later is this excerpt from Plato: "It is very unjust that the homosexual should be accused of immodesty for it is not through lack of modesty that he acts in this way. It is because he has a strong soul, manly courage and a virile character that he seeks his own kind. This is proved by the fact that with age many homosexuals seem to be more efficient than others as servants of the state." Nevertheless, there were times in Greece when, because of public opinion, homosexuals in high public offices were exiled. Under Roman law, although criminals were treated severely, many forms of homosexuality were ignored and no action was brought. Anglo-Saxon law was not as lenient because the moral code of the ecclesiastical courts was accepted as the basis for common law and followed the Bible in its viewpoint. Almost to the present time, therefore, statutes in England were particularly concerned with meting out vengeance (retributive justice). In the United States, just as today in England, science has succeeded in modifying judicial procedures, to the degree at least that informed public opinion has demanded changes.

It is, therefore, advisable to summarize the modern viewpoint of psychiatry, particularly as developed by Dr. Sigmund Freud,¹ for in the last fifty years, due largely to him, his psychology has become a scientific explanation of sex behavior.

Sex is primarily a physical process which is as commonplace as are drinking and eating. Since it does not depend on either good or evil in man, in its origin there can be no question of morality. Sex is instinctual, meaning by instinct a primary urge or impulse which serves a biologic need. Sex in infancy can be regarded,

therefore, as a physical expression of uninhibited impulses which are the result of stimuli. It is for this reason that psychology claims that if its expression is interfered with by a parent, an emotional blocking may be brought into play. If this interference is persistent, painful memories due to it become repressed and retard normal psychologic development.

Sex then begins at birth and not at adolescence. According to Freud,² in the first five years of life both male and female go through similar stages of body-mindedness of which sex is a part. Infants have erotic feelings even though they have not an ego sufficiently developed to understand them. This is particularly true in the relationship of a child to its mother in the act of suckling. Psychoanalysis contends that it does not make much difference whether it is the breast or an artificial nipple which gratifies the infant. Stroking and hugging—in fact, all of the types of affection displayed by a mother—are not merely experienced by the child as a sensory feeling but have also an erotic component. There are psychiatrists who do not accept entirely the viewpoint of Freud that libidinal impulses of infancy are retained in memory and influence psychologic growth. A little later in its life an infant becomes aware of those organs which function in connection with elimination. The release of tension in excretory functions is meaningful and, as Freud showed, brings on satisfactions which are akin to if not the same as erotic feelings.

About the third year of life the child begins to obtain a sense of pleasure from touching his own body and particularly his sex organs. This stage of development is called the phallic one. Its name is derived from the Bacchanalian orgies of ancient Greece in which a huge figure symbolizing the penis or phallus was borne aloft in solemn procession. The final stage of psychosexual development in childhood is the genital one. At this time the child has not only become aware of penis and clitoris but has also become psychically attached, through genital pleasure feeling, to the mother image. Whether this is the time that ego development begins is still a matter of controversy. Dr. Theodore Reik,³ for instance, claims that babies are not self-loving. He denies that an infant is in love with itself and scoffs at the narcissistic theory, calling it a fairy tale deriding the idea of Freud that once upon a time, in early childhood, the ego was in love with

itself. But most evidence points to the truth of Freud's postulate that the love of self (body) commences early in life and, if not tempered by other loving in adult life, is a destructive force.

After the genital stage is reached, boys and girls diverge sexually. It is important to recognize that at this time a child becomes, to a certain extent, aware of its parents as sexual objects. If a male, the mother becomes the object of his love, and if a female, a father object-love develops. In both cases there is some sort of identification with the parent of the same sex in a psychologic effort to be closer to the parent of the opposite sex. It is the part which combinations of these psychologic factors play in the developing ego of the child which is important. For, long before the advent of puberty, a boy's love for his mother or a girl's love for her father may become a dominant influence. The basis of the theory about repression, which later may result in a displacement of sex objectives and in this way bring on a homosexual trend, is dependent on this. Dr. Edward Glover⁴ states that "a child is plunged into love, hatred and jealousy at an age where it has not the ego development to cope with these impulses."

It is understandable, from the above, that psychic conflicts starting at such an early age may result in physical tensions. It is also understandable that those tensions which are connected with elementary physical satisfactions, when they meet up with tensions growing out of the world outside the home, produce conflicts. For conflicts to be intense enough to prevent psychologic maturity implies the possibility that a biologic basis for this also exists. What is called conflict is a commonplace result of living. Everyone goes through conflicts, as Freud showed. Therefore, it would follow that before maturity all human beings are really neurotic. Freud was willing to concede this and acknowledge that there was a gap between our understanding of the constitutional make-up of the child and its psychologic development. He contended that there was a latency period between the sixth year and the period of adolescence. Perhaps there is in the sexual zone, but certainly not in respect to ego development. And it is the ego attachments that are important in the sexuality of both male and female. This is clearly indicated in the conclusions of William H. Perloff,⁵ from which I quote. "Genetic factors exert no influence upon the choice of the sex object. Hormones likewise do

not influence the choice of the object of affection. The choice of the sex object is determined by learned experiences. . . . In the adult, human abnormalities of sexual behavior may usually be considered to be due to psychologic deviations with hormones playing at most a secondary role. . . . And further, homosexuality is a purely psychologic phenomenon, neither dependent on a hormonal pattern for its production nor amenable by endocrine substances to change."

The ego naturally is weak in its early formative stage. Experiencing sensory gratifications, particularly in touching and rubbing its genital organs, a child cannot understand the demands of its parents and the reprimands received. Enforced discipline on a sexual level may tend to produce not only a repression of partially formed memory images but may also bring on a dynamic damming up of emotions. Blotted-out memories on this basis are one of the causes of anxiety states which so frequently commence in adolescence or after marriage.

A repression of this kind brings on, with some children, a tendency to the formation of sexual phantasy. The weak ego is able to develop sexual gratifications in this way. This phase of child psychology is too involved to be elaborated on in this short paper. It is not a product of pathology and is the usual reaction of the male child to wish to replace his father and the female child to desire to substitute herself for her mother.

Whether this marks a final phase of sex development, as claimed by Freud, has not been proved. It has been accepted, however, by the fundamental psychoanalysts who, following Freud, call this the oedipal situation. This complex derives its name from the story of Oedipus Rex, by Sophocles,⁶ the king being killed by his son who was brought up in ignorance of his parents and who then married his own mother. There is no question that many mothers realize the sexual basis of their sons' fondling of them and many reciprocate and stimulate their child in order to get a response. The various psychoanalytic theories connected with the fear of castration in the male child and the absence of a penis in the female child, both of which are parts of the Oedipus situation, cannot be discussed in this paper.

In adulthood, heterosexual intercourse is the only one which has universal social sanction and for the most part only when it is made permis-

sive by civil or church marriage. Because other outlets do not meet with approval does not imply that they occur only in mentally ill persons. In considering homosexuality, a physician must recognize that it is against the common good, that it is a statutory crime, and that also it is opposed to the Christian civilization in which we live. These considerations, because of the commonness of homosexual practices, confronted the military authorities in World War II. They first dealt with the homosexual as a criminal offender, then shifted to discharges with dishonor, and lastly, merely dismissed an offender of this category without qualifications.

René Guyon,⁷ a rationalist and atheist, is one of many who condemn England and the United States for their laws against homosexuality. He also criticizes Freud for bowing to convention and failing to acknowledge that such sexual practices, according to his own writings, are normal. It is true that Freud did say that "Homosexuality is found among persons who have high intellectual development and ethical culture." He did not, however, discuss the social or legal implications. A love for one's own gender is normal. Both men and women have pleasure in associating together. Their self-love is often carried over to a preference for their own sex. This projection, however, is more psychic than physical. When it demands sexual contacts, it is no longer an average or normal expression.

In the framework of conflict and repression, as taught by Freud, there must be some sort of splitting of the ego. Because of this, a displacement such as occurs in a sex deviate becomes understandable. Psychoanalysis tries to reach the unconscious conscience and, through the symbolic revelations of dreams, does so. Psychiatry has learned by a study of dreams the sources for anxiety, emotional immaturity, and social insecurity. The forms of phantasy occurring in dreams reveal how an adult regresses to infantile levels of gratification and becomes a deviate.

All of the different types of sex deviations are based upon the dynamic reactions of the id, the ego, and the superego upon each other. The neurotic person still lives in anxiety and cannot reduce inner tension. The sex deviate is relieved of tension by expressing it through displaced psychosexual outlets. The fetishist, for instance, uses scents or wearing apparel, by means of which through phantasy he finds an outlet for

the repressed sexual love he had had and still has, unconsciously, for his mother. The transvestite, through the use of female dress, imagines himself in this way able to be sexually again united to his mother as he was in the early years of his development. He puts on female clothes in order that in phantasy his female thoughts have reality.

It is a mistake to consider that Freud was antireligious as do some of his critics. Freud even stated that "insofar as religion brushes away men's fears of the dangers of life and comforts them in their misfortunes, science cannot compete with it." Freud had no basic quarrel with religion, although he called it an illusion. His whole argument was based on his contention that it was not founded upon a scientific basis. He was attempting to show that the sex instinct or id dealt only with physical satisfactions and that when it came into conflict with the security functions of the ego there developed a superego which had no supernatural attributes. His superego is not exactly the same as the theologian's conscience because it has both an unconscious and a conscious component.

There is still a void between psychoanalytic and religious doctrines. It cannot be resolved by silence, nor can the two be reconciled in our present insufficient knowledge of behavior outside the sex and neurotic areas. However, I believe that moral issues are involved in the inner life of human beings and influence conduct even though the medical profession at large leaves this problem to the church. I do not accept the sweeping generalizations of the anthropologic school of Margaret Mead who contends, from her study of primitives, that all sex customs are environmental and that cultural psychology rather than religion or psychiatry holds the answer to sex mores. It is a psychiatric contention that all physicians should attempt to understand the total personality of human beings. But the analytic psychiatrist frequently forgets this rule and fails his patient when he ignores chemical and other physical sources of personality, as well as the moral nature of man. Psychiatry is only one field and a limited one in the physician's list of techniques.

At the present time, theology resolves its behavior problems into elemental forces altogether different in their implications from those of psychiatry. I am not referring to differences in dogma and creed. No matter how diverse these

are, they are attempts to give peace of soul as well as ease of body. The psychiatrist says that a sense of guilt urges human beings to crime, to antisocial acts, to perverse practices, and that this guilt feeling is an unconscious one. The need for punishment, often present, psychiatry asserts, is to allay the anxiety produced by the misdeeds of their childhood. Punishment often, therefore, is a means to an end and a prison term for a deviate can be harmful. Every physician knows that he must accept some responsibility for the social and psychologic life of his patient as well as for his physical complaints.

There is at the present time a development in the great religions of the Western world, exemplified in the writings of Martin Buber, Felix Barth, and Jacques Maritain, which in my opinion is helping greatly to reconcile psychiatry and religion in their differences. Dr. Reinhold Niebuhr,⁸ a Protestant leader, also must be considered as well as Monsignor Fulton J. Sheen⁹ in the present issue between religion and psychiatry. Dr. Niebuhr, though he agrees that Freud has "illuminated men's weaknesses," states that "he has also reduced them." The "I" of the theologian's personalism, whether looking in at himself or up towards a higher being, is of course something different from the ego as depicted by the psychiatrist. With the one, the soul and the "I" can be one. With the other, they always remain separate. C. J. Jung did both psychiatry and religion a disservice in his incoherent writings in which pagan beliefs and a mystical sort of Christianity were presented as a psychiatric contribution. He reminds me of Plato who, in his *Symposium*, likened Eros to God.

The necessity for some sort of bridge between religious and psychiatric ideas is admitted. When an attempt is made to understand the psychopathic group, among which the sex deviate is classified by many, this necessity is made plain, for the problems of morality cannot be divorced from any description of a psychopath. Indeed, except on a socio-moral level, just what is meant by a psychopath defies definition. I was interested in going over the last book written by Freud in not being able to find the word psychopath in it. Dr. Otto Fenichel,¹⁰ whose book is today the Bible of the psychoanalyst, at the introduction of the chapter on perversions states that "perverts and impulse neurotics are sometimes not called neurotics at all but psychopaths." Hervey Cleckley,¹¹ in his discussion of the homo-

sexual person, says that "no one more than the writer is in accord with the belief that psychopathic sexuality is abnormal." But, "one is struck by the absence rather than the presence in psychopaths of the kind of sexual aberrations usually described in the works on the psychopathic personality."

Throughout the literature on psychopathic states and that on sex deviates, irreconcilable differences exist which show how far we are from a scientific basis in psychiatry in considering these groups. Fenichel, to quote him again, states that "the symptoms of neurotics are disguised perverse acts. Perverts are persons with infantile instead of adult sexuality." In this sense, therefore, there can hardly be any reality in calling a sex deviate a psychopath. The analytical psychiatrist, following Freud, believes that a perversion is always due to a fear of castration which is the basis for a regression and through which the infantile components of sexuality are perpetuated. Arthur Noyes¹² concludes that "a neurotic expresses his unconscious psychic conflicts symbolically through symptoms and the psychopath expresses his conflicts through stereotyped activities which are against his own interests and who, in carrying them out, shows an excessive and unwarranted hostility to his family and friends."

Psychopaths are either in conflict with the law or the center of discord in the home. No one can predict either what or how they will do things. Like the Flying Dutchman myth, their tempo is sped up as if fate was always at their heels attempting to catch up with their misdeeds. It is claimed that they do not "feel into" their relations with society at large so that they cannot develop a sense of moral values. This is not altogether the case, however, because many of them are basically neurotics although aggressive and show a sensitivity that is more extreme than that of the average person. Some know that they are hurting themselves. They often are most remorseful. Yet there is a compulsive urge that makes them do things which are antisocial. This is the situation commonly found in the active homosexual group. There is no defect of intelligence even though emotional maturity has not been attained. There would seem to be some defect which produces a lack of volitional control and which makes them unable to put on the brakes as does the average citizen. In this group, whenever sadistic impulses dominate and partic-

ularly when aggressive sexual acts occur, the committed offender should be put away indefinitely. A psychologic and psychiatric study, as well as a physical one, should be furnished and motivate the court in the disposal of an offender. A first offender, for instance, may be more of a menace to society than a recidivist.

The mental hygiene movement has sponsored many programs which involve possible preventive measures. Little progress in prevention, however, has been made, for few schools have visiting teachers, few communities have child guidance clinics, and the psychologic needs of children are not handled efficiently by the teacher. The public is still uninformed and therefore demanding that the taboos be enforced, for the sex deviate violates the conscience of the average citizen.

The biosocial as well as the psychologic basis of sex behavior must be taught in the formative periods of growth. There is still too much controversy about who shall give sex education. Shall it be the teacher or the doctor, the minister or the parent who gives sex instruction? How can our cultural and religious differences be eliminated in order to break down the barriers so that an understanding of modern biology and psychology can infiltrate itself into the home and influence the American mores?

The laws dealing with the sex deviate vary greatly.¹³ In several states a nudist can be convicted as a criminal. Even the meaning of the words used in defining a sex offense differs in various states. And in many states the laws refer only to the male deviate and do not include the female offender. Only about 5 per cent of those convicted of being a sex deviate are in a legal sense mentally ill. The social and legal problems of the sex deviate, therefore, cannot be considered to be only the concern of the psychiatrist.

The accidental and occasional adolescent who submits to some type of sex practice which does not receive social sanction is, for the most part, an average normal human being. Not having reached biosocial maturity, his arrest accentuates his confusion, aggravates his insecurity, increases his inadequacy, and also injures his reputation. Emotional tensions are in this way built up so that frequently they bring on a panic reaction and initiate an asocial attitude. Publicity creates scorn as well as pity in his home and often helps to have him drift into the very group which society asks him to avoid. There should be some

way of dealing with this perplexed and confused group other than jailing them. The majority of these young offenders have no compulsive drive, are amenable to treatment, and should be referred to a treatment clinic. In the last Allegheny County Behavior Clinic report,¹⁴ I suggested that it should function as a treatment clinic so that referral would avoid subjecting an alleged sex offender to a jail sentence.

To conclude, the drama of sex begins in childhood and many psychologic and biologic situations produce deviations in sex development. The basis for narcissistic displacements, for guilt feelings, and for defensive sadistic impulses can be laid bare to an adolescent so that he can adjust to and control his tendencies even if they cannot be eradicated. I have purposely not discussed the inadequacies of Pennsylvania statutes and the inability of our understaffed and overcrowded mental hospitals to deal with the sex deviate. Such a discussion would take me far afield and unnecessarily prolong this paper beyond allowable limits.

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DISCUSSION

RODNEY H. KIEFER (Pittsburgh): Dr. Mayer has presented an interesting discussion of the sex deviate, and I think a very timely one. Here in Pittsburgh it is an acute problem right now. This past year I have seen over 200 homosexuals held for Criminal Court here in Allegheny County.

Certainly wars and postwar periods seem to accentuate the homosexual problem. Very often the story elicited from these individuals is that their first homosexual experience occurred while they were in the service, and this is particularly true of the latent homosexual. He was able to suppress these drives in his normal civilian life, but when placed in a homosexual

environment, with the stresses associated with that environment, he frequently lost his inhibitions and committed overt acts.

Our attention was focused on this problem in Pittsburgh this year by certain business firms complaining that large groups of homosexuals were frequenting these business establishments and annoying their patrons. A special vice squad was organized to cope with this problem, and it was not uncommon to see ten to twelve homosexuals being arrested every evening. They were held for Criminal Court in this county. Those of us who are interested in medical psychiatry were, of course, immediately impressed by this large number, and asked ourselves: Why are these individuals held for Criminal Court in this Commonwealth, whereas if they had committed the same act in Vermont or New Hampshire it would not have been considered a crime? And yet, if they are held for Criminal Court in this Commonwealth, they can be punished by five to ten

years' imprisonment. If they committed the same act in Colorado, they could be given a life sentence. I point this out merely to emphasize the discrepancies of our state legislatures in handling this problem and the great confusion associated with it.

By and large, these individuals were arrested for the first time. They lost their reputation, their job frequently, and suffered definitely as a result of just a single arrest.

I feel that many of these individuals are seeking treatment but are being wrongly advised. The family physician is certainly the one to direct them properly. He can often prevent certain psychosomatic manifestations. By his sympathetic understanding and knowledge of the homosexual problem, he can help these people to find a better position in life. We do not expect, of course, to cure very many with psychotherapy, but in the long run it does benefit the patient, his family, and society as a whole.

MEDICAL PERSONALITY

There are certain qualities which distinguish and characterize the members of the medical profession. Even though they may seem somewhat nebulous and intangible, they are actual and real. They are determining factors in the character and extent of the physician's practice. They are described and designated by three words, "ability," "amiability," and "dependability."

There can be no substitute for ability. It is almost entirely acquired. Only a very minor part can be due to "being a natural born doctor." It is acquired by long hours of concentrated study, by correlating facts and diligent application, by profiting from actual experience, attending medical meetings, and personal contact with fellow practitioners.

The personality trait, amiability, can and must be cultivated. It manifests itself in a spirit of cooperation. The practitioner needs the pathologist and his laboratory, the roentgenologist and his x-ray, the surgeon, the internist, and other specialists. They, in turn, because of their specialized skills, need their fellow practitioners if the patient and the disease are to be treated.

Amiability manifests itself further in a spirit of sympathetic understanding and humility. This does not denote a lack of self-confidence. Medicine now has a scientific basis which gives the physician a firm and reliable foundation. However, it is not an exact science, and errors in judgment are bound to occur.

Furthermore, there is the troublesome "personal equation," the sprained ankle, which x-ray examination a week later showed to be a fracture; the secondary anemia which was readily detected, but the carcinoma that was overlooked. Every physician can readily add numerous other incidents from personal experience.

Dependability is the sine qua non of medical practice. It is the essential ingredient in the art of medicine. It is conditioned by the physician's attitude toward his work, the manner in which he discharges a most disagreeable duty, and the courage and fidelity with which he meets responsibility. When discharged with loyalty and cheerfulness, the compensation in personal satisfaction overshadows the financial reward.

Medical personality is already present in the medical student, and it is something that must grow day by day throughout the physician's entire career. Its reward to the physician is a feeling of work well done. Each day will then bring something different, new, interesting, intriguing, and problems that require all his resources in order to solve correctly. The profession itself will receive approval from the public, which of late has been unduly critical.—HARRY VANDER KAMP, M.D., *Wisconsin Medical Journal*.

DOCTORS' PATIENTS ARE BLUE SHIELD PROSPECTS

A vast market of Pennsylvanians who do not have Blue Shield protection against the costly hazards of serious illness and injury provides participating doctors in the Medical Service Association of Pennsylvania with an opportunity to interest many of their patients.

Only approximately 22 per cent of the country's eligible population is enrolled for surgical coverage in voluntary prepaid medical care plans, according to figures from a recent joint study made by the AMA Council on Medical Service, Associated Medical Care Plans, and the Health Insurance Council.

Tuberculosis as a Complication of Silicosis

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TUBERCULOSIS is not only a common complication but also a very serious complication of silicosis. The death rate from tuberculosis among industrial workers exposed to heavy concentrations of silica dust is higher than that of the population as a whole. Considerable experimental and clinical evidence indicates that silicotic lungs do not tolerate tuberculous infection as well as normal lungs. The reasons for this difference are not clearly understood.

Silicosis and tuberculosis are two separate pathologic entities. Their coexistence, however, frequently gives rise to a chronic condition which has been termed silicotuberculosis. Silicosis is caused only by the inhalation of fine particles of silicon dioxide into the lungs. Tuberculosis is an infectious disease caused solely by the tubercle bacillus. Neither disease can be produced without its specific etiologic agent. In their early stages essentially the same body defense mechanisms are brought into play. The dust particles or the bacilli are carried by epithelial cells or phagocytes into the lymphatic channels, where they are transported to the lymph nodes at the roots of the lungs. In the course of their journey some are deposited and retained in the small collections of lymphoid tissue in the lung parenchyma. The tissue response at this point is similar in both diseases in that fibroblasts form around the dust particles or bacilli in an attempt to wall them off. Also, there is a chemical reaction set up in the lungs from the dust particles. The amount and the distribution of the dust in the lungs therefore determine the extent of the resulting pathology. Hence, spread of silicosis is dependent upon the volume and size of the inhaled dust particles, while the progression of tuberculosis is dependent on the multiplication of the bacilli themselves. The resulting fibrosis caused by these two different etiologic agents is difficult to differentiate, and an evaluation of their independent roles as a cause of illness is

frequently not possible. In clinical diagnosis, therefore, it is essential to correlate occupational history, symptoms, physical signs, x-ray appearance, and laboratory findings.

When tuberculosis is a complication of silicosis, the infection may arise from either endogenous or exogenous sources, i.e., by the escape of tubercle bacilli from a pre-existing tuberculous focus, or by the inhalation of bacilli from an outside source. In either instance, changes in the lung tissue caused by the infection alter the characteristics of the silicotic process. As a result, the clinical and pathologic picture changes and the prognosis becomes more unfavorable. However, when active or quiescent tuberculosis is present prior to exposure to the silica dust, the subsequent pathology is altered by the amount of dust inhaled, the size of the particles of free silica, and the relative amount of the non-silicious components. In heavy concentrations of free silica under 5 microns in diameter, the dust particles accumulate around the tuberculous focus and may actually retard the process by building a surrounding wall of dense fibrosis. Progression of the tuberculosis is then retarded and tubercle bacilli may not appear in the sputum for long periods of time. In light concentrations of free silica with high non-silicious components, the dust particles have the same tendency to accumulate around the tuberculous lesions and to add to the existing fibrosis, but they have no significant effect on localizing the infection.

In the majority of cases of silicotuberculosis the tuberculous infection takes place before the development of the silicosis, but it may occur at any time during the course of the disease. To establish the presence of early active tuberculous infection in silicotic lungs is difficult at times because symptoms may be delayed and laboratory findings may be negative for many years. It is well to keep in mind that a negative tuberculin test will exclude the possibility of a tuberculous infection. Diagnosis must be confirmed either by

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positive laboratory findings or by x-ray changes and symptoms suggestive of progressive tuberculosis. The presence of tubercle bacilli is the one finding which by itself will establish a diagnosis of active tuberculosis. Therefore, an intensive search for the organism in the sputum must always be made. This should be done by examination of sputum concentrates, cultures of the bronchial secretions, or gastric washings. However, it must be remembered that active tuberculous infection may be present even though tubercle bacilli cannot be demonstrated. When the sputum is negative, cough, expectoration, loss of weight, pleurisy, hemoptysis, or afternoon temperature are important diagnostic considerations. In the absence of a positive sputum, visualization of the pulmonary pathology by serial x-rays is the most reliable method for determining the existence of tuberculosis. In these x-rays evidence of cavities or the presence of conglomerate shadows, particularly in the apices and upper lung fields, is suggestive of tuberculous pathology. Also, progressive soft appearing mottled shadows, which are changing more rapidly than shadows caused by silicotic nodulation, point to possible tuberculous pathology. When the sputum is negative, it is only by clinical acuity and painstaking study of all the factors that the presence of significant tuberculosis in silicotic lungs can be recognized with any degree of certainty.

While tuberculosis is a frequent complication of silicosis, certain other conditions such as malignancy, fungus infections, pulmonary suppuration, bronchiectasis, infectious bronchitis, and pulmonary fibrosis may simulate tuberculosis. Their differentiation is important not only from the standpoint of treatment but because of the medicolegal implications.

The treatment of active tuberculosis in the presence of silicosis is essentially no different than the treatment of tuberculosis alone. Patients with active disease should be removed from work immediately. Institutional care is desirable

for the purpose of isolation, proper rest, and the utilization of definitive methods of treatment. Streptomycin may be helpful in either acute exudative or miliary disease. However, streptomycin is of limited value in chronic fibroid or cavernous disease. The presence of silicotic fibrosis in infected lungs presents difficulties in establishing collapse therapy. Such therapy is frequently impractical because of an already lowered vital capacity caused by the silicosis and the extensive pleural adhesions which are usually present.

The management of chronic silicotuberculosis presents a somewhat different problem. Many of these patients are quite capable of continuing work under suitable conditions. For instance, if their job involves undue silica exposure, a change to a less dusty environment is advisable. Also, each case must be studied to ascertain the amount of physical activity which can be carried on with reasonable safety. Patients permitted to continue work must be under close medical supervision.

Disabling silicosis or silicotuberculosis is compensable in Pennsylvania under the Occupational Disease Act. Under the law, disability must be total and permanent before compensation can be granted. The present law does not provide protection for the worker with partial disability. However, when the tuberculosis is not showing evidence of progression and the sputum remains free of tubercle bacilli, suitable work on a dust-free job frequently can be continued with reasonable safety. The time when all work should be discontinued is difficult to determine.

In general, the results of treatment of active tuberculosis complicating silicosis are not satisfactory. While the infection will be arrested in some patients, particularly those with early disease, the death rate from tuberculosis complicating silicosis is high. In the last analysis, the solution of the problem rests in the elimination of silica hazards in industry and the prevention of exposure to tubercle bacilli. Both silicosis and tuberculosis are preventable diseases.

CARCINOMA OF THE COLON AND RECTUM

Modern Trends in Management

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WHEN one mentions cancer of the colon, the reaction, all too frequently, is one of hopelessness. We can say truthfully that such an attitude need not exist, but that it does few will deny, and we must recognize it, analyze the causes, and strive in every way to correct it.

The reasons undoubtedly are that, even now with all the educational campaigns, only about 50 per cent of colonic and rectal carcinomas are seen at a time when they are removable, and in rural sections the percentage will be much less, I feel sure. Because of this, only palliative measures can be carried out on far too great a percentage of cases. Such a state of affairs is a real challenge and the profession is not by any means wholly responsible.

Cancer is the most frequent tumor of the colon, and that it is seemingly on the increase is probably more apparent than real, due to better diagnostic methods and the fact that more people are reaching the so-called cancer age.

Improvement in the management of colonic cancer with a gradual lowering of the mortality of radical operative procedures has evolved over many years until now reasonable limits have been reached when all is considered. One cannot think only of the mortality statistics if many of these otherwise hopeless conditions are to be given their chance for cure.

Cancer of the colon is a slow growing tumor susceptible to cure by radical surgery, but it must be seen in its early stages if these cures are to be obtained.

Early diagnosis therefore is, as always, the first requisite in colon surgery and a little time given to our best means of early diagnosis would seem to be in order.

We have no intention of attempting to enumerate all of the chain of symptoms caused by a cancer of the large bowel, and it would be very

difficult, if not impossible, to do so if only the early manifestations were to be considered. We can only try to stimulate renewed interest in the subject generally and urge all to insist on a thorough investigation in all suspicious cases, especially for those at or after middle age. It is only by such means that we can hope for real improvement over the present state of affairs.

Absence of alarming symptoms probably has much to do with failure of earlier recognition, and it appears that some lesions do not cause enough trouble to attract attention early, but it would seem that the vast majority having carcinoma of the bowel would give a history of some symptoms of disordered bowel habit if questioned carefully. It is such a frequent thing to hear patients complain of some bowel dysfunction that all too often the warning change may be missed and the chances of making an early diagnosis lost unless the possibility of such a condition is always considered.

What should make us suspect the existence of a carcinoma of the bowel? Rectal bleeding must receive a most careful investigation and malignancy be excluded before any minor type of surgery is performed, because this is one of the most important symptoms of cancer of the colon and rectum. A definite change in the bowel habit, especially constipation of recent origin, in a person of middle age or beyond, only overcome by purgatives, is very suggestive of malignant disease of the colon. Chronic diarrhea also frequently proves to be due to cancer of the colon. A change that persists for weeks is certainly indicative of bowel malignancy, and any change at all calls for a most careful investigation, usually including roentgenologic examination by a competent man, because 90 to 95 per cent of cancers of the entire colon present nothing more definite in the early curable stages and x-ray is the most satisfactory single diagnostic aid for growths beyond the view of the proc-

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toscope. Symptoms such as great loss of weight, cachexia, dehydration, and the like, commonly named in textbooks, are really those of metastasis and palliation is all that can be hoped for under such conditions.

Generally speaking, the right half of the colon is the absorbing half and beyond the middle of the transverse colon the function is that of storage. In the right half are seen the large flat ulcerating growths which give rise to the profound intoxication and anemia without the tendency to obstruction. Here, due frequently to pain, indefinite dyspepsia with perhaps some noticeable loss of weight and strength, the condition is often diagnosed as chronic appendicitis or cholecystitis and the true lesion found only at operation.

In the left half the lesions are predominantly obstructive in symptomatology. Outside of the rectum the two mobile segments of the colon, the cecum and sigmoid, are the most frequent sites of carcinomatous growths.

When treatment is considered, it is unquestionably surgical from the standpoint of curability, and even if the lesion has reached the stage where radical measures cannot be carried out, some sort of palliative procedure may often be employed which will prove of great benefit.

The operation that effects wide removal of the growth and a re-establishment of the normal bowel continuity, or without the necessity of a permanent colostomy, thus preserving the valuable sphincter mechanism, is, of course, the most ideal. This type of procedure has for years been applicable to the proximal colon and has gradually been extended to the low sigmoid and rectosigmoid areas, but until comparatively of recent date the risk has been so great, and the conditions found where it could be safely applied have been so few, that it has had a rather narrow field of usefulness in the lower left bowel.

While the generally accepted treatment of malignant lesions of the bowel is surgical, there is still some controversy regarding its application. Technical details are quite out of place here and the time allotted permits consideration of only broad general principles. The operative procedures generally utilized today are, with few exceptions and modifications, those developed by surgeons working in the last century, mostly in the eighties and after. Miles in the early part of this century has probably made the greatest single contribution to the cure of cancer in the

lower sigmoid and rectum by developing the operation that bears his name.

In surgery of the colon, individualization or careful selection of the operative procedure best suited for the conditions found is, indeed, most important. As stated, there is a marked difference in the physiology of the right and left half of the colon and also in the symptomatology and clinical findings when involved by malignant changes, yet the tendency today is to revive and extend the application of the one-stage operation for all when acute and total obstruction does not exist. There is no question but that such can be applied more successfully and in a larger percentage than has obtained in the past due to better preoperative preparation and the more liberal use of blood and its substitutes as well as vitamins and antibiotics, but we must use caution in the wider application of the one-stage operation in any area and especially on the left colon or rectum. With all due respect to anyone's favorite suture material and technique, the left colon often has a scanty blood supply as well as a virulent fecal content, thus one cannot depend upon getting primary union at the suture line. There is little doubt but that the use of interrupted sutures of any type will interfere less with healing at the anastomotic site than will the use of continuous sutures throughout.

Because of the liquid content and thus the usual lack of obstruction when the proximal colon is involved, the one-stage procedure has been utilized more frequently here than has obtained in the more distal areas as a rule. The right colon may be removed in a variety of ways. A preliminary anastomosis may be made between the ileum and transverse colon, and after it is functioning well the involved colon may then be removed. The entire resection may be carried out as a one-stage affair and the ileum joined to the transverse colon either end to end, side to side, or end to side, and as long as it is done properly and has an adequate blood supply the results, as far as I have ever seen, are equally satisfactory. The Mikulicz principle also has a wide field of usefulness.

There seems little doubt but that a one-stage resection may well replace the modified Mikulicz operation in the left colon with success more frequently than has been obtained in the past because of better preparation and treatment: however, if some degree of obstruction exists or there is much reaction about the growth or fixation to

contiguous structures, no matter whether the patient is young or well advanced in years, we feel that a preliminary colostomy of the Devine type and a period of non-function or debacterIALIZATION at the site of the growth would insure a lower mortality and morbidity as well as a more radical resection.

All doing colonic surgery have had a fistula appear unexpectedly at the anastomotic site I feel sure; at least we have, as proved by barium enema prior to closure of the colostomy. Perhaps these patients would have survived the one-stage operation, but such experiences have made us continue to utilize the two-stage procedure for most lesions in the left colon. Following resection of the right or left colon, we have never considered it necessary or desirable to cover the gutters, or areas from which the colon was removed, with peritoneum. For lesions of the left colon too low for the successful application of the Mikulicz principle, we usually do a proximal colostomy of the Devine type if any form of anterior anastomosis is considered. We feel that Devine, by advocating his principle of non-function and debacterIALIZATION prior to resection of low-lying lesions, has made one of the best contributions of modern times.

Sphincter-saving operations have naturally been attempted for many years and, of course, if the operation can be done and gives promise of the same result, it is, as was stated, incomparably the more acceptable. Many ingenious operative procedures have been devised and used to re-establish bowel continuity following resections for lesions in the lower sigmoid and rectum and with much success providing their application was kept within reasonable limits. The best results in the past have been obtained when a cecostomy or colostomy was performed either before or at the time of resection and anastomosis.

Hochenegg, in 1888, suggested and performed the pull-through operation for rectal carcinoma. He freed the pelvic colon by the abdominal approach and then excised the diseased segment of the rectum or the whole rectum by way of the perineal route and pulled the healthy distal end of the sigmoid through the anal sphincter muscles. This appeared to be the operation of choice for low rectal cancer, but arguments against it

soon appeared. First, the nerve supply of the internal sphincter in too low amputations of the rectum was so damaged that the mechanism of involuntary control was either greatly compromised or lost, and again the operation was not radical enough to excise the perirectal tissues which were shown often to be the site of secondary spread of the growth. This operation with some modifications is enjoying a rebirth and maybe the early errors are being corrected, but not if the sphincter mechanism is preserved intact because, if so, the operation is not considered sufficiently radical to meet the standards of curability as shown today for growths below an average of six centimeters from the anal or dentate margin. Wide excision of the perianal tissues is indicated in such conditions because, contrary to what some have been led to believe, metastasis occurs not only upward but laterally into these perirectal tissues or there is even a nodal spread in that direction in many instances.

In the light of our present knowledge, there is little question but that the Miles operation or some modification equally or even more radical is the operation of choice for malignant growths situated lower than six centimeters from the anal margin, and low anterior resection is definitely contraindicated as is any other sphincter-saving operation because it is not radical enough. The Miles type of operation, or one that is even more radical in its attack on the perirectal tissues, is indicated, as a rule, for growths much below the peritoneal reflection; and when such radical measures are carried out on the average case, a preliminary colostomy should receive careful consideration. Such an extensive operation is shock-producing even though the patient is in the best of condition, and those considered for it should be selected with care, especially if a more radical procedure than even that advocated by Miles is contemplated.

We must not lose sight of the fact that re-establishment of bowel continuity is not the primary consideration and that a colostomy is compatible with a very useful and comfortable life. Unless, therefore, practically the same chance is offered by a sphincter-saving operation, it should never be mentioned to the patient or considered in the treatment of cancer of the rectum.

TUBERCULOSIS IN INFANTS

Report of Two Cases

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WHEN tuberculosis occurs within the first year of life, the question ought to be raised as to whether or not infection occurred within the neonatal period. Reviews of the subject of congenital tuberculosis and case reports appear in the medical literature,¹⁻¹² and these have listed criteria for establishing the neonatal development of the infection such as: (1) the tuberculous nature of the lesion must be proved; (2) a primary complex in the liver is proof of the congenital nature of the infection; (3) if no primary complex is found in the liver, tuberculous changes must be found in the fetus at birth or a few days after birth; and (4) extra-uterine infection must be excluded with certainty. In the last instance, cases of tuberculosis in infants have been accepted as congenital infections when the infant has been separated from a tuberculous mother immediately after delivery, usually because of the severity of the disease in the mother.

According to the number of cases reported, congenital tuberculosis is apparently rare. Of 35 cases of tuberculosis in infants, collected from the literature between 1935 and 1945 by Hughesdon,⁶ 11 were proved to be congenital infections and 15 were probably congenital. Of this group, some fetuses became infected by the transplacental blood stream route, others by the ingestion or aspiration of infected amniotic fluid, and still others had skin lesions from contact with infected amniotic fluid. Occasional additional cases have been added to this list. Beitzke¹ collected 101 cases of congenital tuberculosis from the medical literature prior to 1935.

In a considerable number of the reported cases of congenital tuberculosis, adequate surveys of other members of the family have been made and in many instances the mother had far-advanced

tuberculosis. However, in two of the cases reported by Hughesdon the mother had symptomless pulmonary tuberculosis at the time of the birth of the infant, and in another instance all other members of the family were well and remained so as long as they were followed three and one-half years after the pregnancy.

The clinical signs and symptoms of tuberculosis in very young babies have been fairly uniform and are cough, jaundice, anemia, enlargement of the liver and spleen, clinical signs of bronchopneumonia, and rapidly fatal termination. Most of the reported cases of congenital tuberculosis have occurred in the first six months of life, but Chiari⁵ reported one case in a child who lived to the age of 25 months, and one of Hughesdon's patients lived to the age of 27½ months. One of the two cases reported here had a clinical pattern similar to that described by others, and this one was unquestionably a case of congenital tuberculosis. In the other patient the congenital origin of the infection was not established and the clinical course was rendered bizarre by the development of tuberculous peritonitis.

Case Reports

CASE 1. B. E., white female, aged 4 weeks. The infant was born at St. John's General Hospital Sept. 20, 1948, and was apparently well at the time of dismissal from the hospital ten days later, but returned acutely ill Oct. 18, 1948. For two weeks she had suffered from progressively rapid and difficult respiration, cough, and fever. The infant was dehydrated and cyanotic. The liver and spleen were enlarged. A roentgenogram of the chest demonstrated a diffuse infiltration throughout both lungs suggestive of bronchopneumonia. The blood hemoglobin was 11.7 grams and the leukocyte count was 2800 per cu. mm., of which 42 per cent were juvenile neutrophils. The temperature ranged from 101 to 103 degrees. Supportive therapy and penicillin were ineffective. The terminal event was a series of convulsions. Death occurred on October 21, three days after admission.

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Necropsy was performed within two hours after death and the major anatomic diagnoses follow:

1. Congenital tuberculosis with primary complex in umbilical vein and in gastrohepatic lymph nodes.
2. Diffuse confluent and miliary tuberculosis of liver, spleen, lungs, thymus, and adrenals.
3. Tuberculous ulcers of ileum and colon.

After the necropsy all members of the family—the father, mother, and two sisters—were asked to report to the hospital for roentgenograms of the chest. The roentgenogram of the mother's chest showed reinfection tuberculosis which involved the upper field of the right lung: Associated with this there was pleural thickening secondary to an old inflammatory disease involving the right lower lateral portion of the chest. There was evidence of arrested reinfection tuberculosis of the left apex. The mother had no symptoms referable to this infection. No other members of the family were infected.

CASE 2.—J. K. F., Jr., white male, aged 8 months, was born at St. John's General Hospital May 10, 1948. The child was breast-fed in the neonatal period, which was uneventful. Formula feeding was instituted later, but the exact time was not recorded. At the age of three months the baby was hospitalized elsewhere for bronchopneumonia which seemed to be refractory to penicillin. During that period of hospitalization an abscess developed in the baby's right buttock which eventually became a draining sinus. The patient was readmitted to St. John's General Hospital, Jan. 17, 1949, via the emergency room. Acute abdominal distention and fecal vomiting had developed and progressed over a thirty-six hour period. The abdomen was acutely distended and peristalsis was hypoactive. The temperature was 105.6° F. and respirations were 70. A scar and draining sinus were present on the right buttock. The rectum was normal. The weight was 18 pounds (8.2 Kg.). An enema was returned clear. The infant died two hours and fifty-five minutes after admission. Necropsy was performed promptly and the major features of the anatomic diagnosis follow:

1. Disseminated confluent and miliary tuberculosis of the lungs, spleen, gastrohepatic lymph nodes, and right kidney.
2. Tuberculous peritonitis.
3. Tuberculous ulcer of the jejunum.
4. Tuberculous sinus of the right buttock with scrofuloderma.
5. Toxic ileus.

The tuberculous peritonitis was given a separate designation because it was apparently the cause of the ileus and death. The tuberculous ulcer of the jejunum and the sinus of the buttock were given separate designations because they may have represented primary sites of exogenous infection.

The family was asked to report for roentgenograms of the chest, and all members of the household which included the mother, father, maternal grandparents, and a maternal aunt complied. None of these relatives had any evidence of active tuberculosis, but in the roent-

genogram of the aunt there were several small shadows along the upper border of the sixth rib on the right side. These suggested the possibility of a minimal juvenile type of tuberculosis. From these studies it was not clear that the infection was transmitted to the child from other members of the family, and the source and primary focus of infection were not determined.

Comment

In the first case the typical signs of tuberculosis in infancy—*anemia, hepatomegaly, and splenomegaly*—were present. In addition, a leukopenia was noted. This feature is not surprising in view of the type of infection, but leukopenia as a part of the syndrome has not been previously emphasized. In fact, leukocytosis has been noted in some of the reported cases. Neither of the two children of this report was jaundiced. Bloody diarrhea has occurred in some of the cases reported in the literature but was not a symptom in either of the cases reported here. In spite of the regularity with which this series of clinical signs appear in reported cases of congenital tuberculosis, the syndrome does not seem to be specific for this disease.

In this case, for purposes of differential diagnosis from both clinical and gross pathologic standpoints, the following diagnoses were considered: (1) Letterer-Siwe's disease, (2) toxoplasmosis, and (3) histoplasmosis. The absence of petechial rash rendered Letterer-Siwe's disease a remote possibility. Tuberculosis was not seriously considered as a likely diagnosis by either clinician or pathologist at the time of necropsy until acid-fast bacilli were demonstrated in a number of tissues including the bone marrow. It is apparent from this that bone marrow studies would be of value in more favorable cases of this type, but none were performed prior to death for the reason that the child was obviously moribund.

A surprising clinical feature was the good nutrition of both infants and the fact that in neither case was the family sufficiently concerned about the seriousness of the illness until the children were moribund.

At necropsy, both cases presented striking involvement of the lungs, liver, and spleen by coalescent solid tubercles up to 0.5 cm. in diameter. In both patients the lymph nodes of the gastrohepatic ligament were large, matted, and caseous. In the first case, the presence of a larger caseous tubercle 1.5 cm. in diameter along the course of the umbilical vein indicated that the

infection was transmitted by way of the blood stream from the placental site during fetal life.

In the second case, the history of bronchopneumonia which was refractory to penicillin at the age of three months suggests the possibility that tuberculosis was disseminated at that time. The abscess of the right buttock was evidently tuberculous because the residual sinus tract was proved to be tuberculous at necropsy. The family attributed this abscess to an injection of penicillin, but it is interesting to note that in the case reported by Harris et al.⁵ the infant had subcutaneous abscesses and was receiving liver therapy by injection, although no mention was made as to whether or not the abscesses developed at the actual site of injection. When disseminated tuberculosis exists in infants, it therefore seems possible that abscesses may develop at sites of injection of therapeutic substances as the result of localized decrease of tissue resistance. In this case the liver and spleen were enlarged, but this clinical feature was masked by abdominal distention.

Summary

1. Two cases of tuberculosis in infants are reported.

2. One of these may be added to the list of reported cases of tuberculosis proved to be congenital in origin because of the primary complex in the liver. Tuberculous infection in the mother was readily demonstrated.

3. The second case may have been one of con-

genital tuberculosis, but the necessary criteria for proving that infection occurred during fetal life are lacking. In this case the mother was apparently free from tuberculosis and no tuberculous contacts were found.

4. The commonest clinical signs of tuberculosis in infants are anemia, hepatomegaly, splenomegaly, and evidence of bronchopneumonia. Jaundice, a common sign, and bloody diarrhea, a more occasional sign, were not present in our cases.

5. Leukopenia, noted in one of our cases, does not occur with regularity in tuberculosis of infants.

6. Tuberculous abscesses at the site of injection of therapeutic substances are suggested as a possible consequence and sign of disseminated tuberculosis.

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TODAY'S HEALTH

A change in name to *Today's Health*, effective with the March, 1950 issue, is announced in the January *Hygia*, health magazine of the American Medical Association.

The masthead of the January number also carries for the first time the name of Dr. W. W. Bauer, Chicago, as editor, succeeding Dr. Morris Fishbein, Chicago. Dr. William Bolton, Chicago, is the new associate editor, succeeding Dr. Bauer. Ellwood Douglass will continue as managing editor.

Hygia was established by the American Medical Association in 1923. Written for the layman, it has come to be one of the most widely quoted health education periodicals in the United States. There will be no change in fundamental policy under the new editorship or new name.

NON-GROUP AGREEMENTS ISSUED BY BLUE SHIELD

The Medical Service Association of Pennsylvania is now issuing agreements to subscribers on a non-group basis which contain certain limitations on the services covered. When a patient presents a Non-Group Identification Card, the participating doctor should remember the following limitations:

(1) Waiting periods of one year for removal of tonsils and adenoids, for treatment of conditions existing at or prior to enrollment, and for medical care of conditions resulting from pregnancy.

(2) Waiting periods of two years for obstetric delivery and other surgery resulting from pregnancy.

Payment for such services provided prior to termination of the waiting periods is the direct responsibility of the patient to the doctor.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

KEYSTONE SURVEY OF PUBLIC HEALTH FOR PENNSYLVANIA

A series of guest editorials inaugurated in the October, 1949 issue, at the request of the Editor, by Chairman Lucchesi of the Society's Commission on Preventive Medicine and Public Health is renewed in this issue and will, it is hoped, be continued through a number of issues. They are expected to be helpfully critical at times, but only in an effort to realize health benefits for the people of Pennsylvania that should stem from a study of administrative practice in public health in the Keystone State as made in 1948 by representatives of the American Public Health Association.

The survey was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania. The Society received 536 copies of the 340-page report known as "Keystones of Public Health for Pennsylvania" and distributed them judiciously to individuals and institutions throughout the State, but there is great demand for additional copies.

If the next session of the Pennsylvania Legislature, avoiding the illogical generosity of the last session (one-half billion dollar veterans' bonus), could be persuaded to adopt the recommendation from our 1949 House of Delegates which is appended, doubtless the Health Depart-

ment could more adequately meet many of the recommendations of the "Keystones" report:

"A system applied to all public health personnel which will include the best modern practices in recruitment, methods of selection, permanence of employment, equality and adequacy of pay, impartial treatment, and provisions for economic security upon retirement."

The guest editorial which immediately follows these editorial comments should be read by all Pennsylvania practicing physicians inasmuch as it unfavorably contrasts infant mortality rates in Pennsylvania with those of neighboring states, and maternal death rates between "several counties in which the rate is still unnecessarily high." These mortality rates may reflect the quality of private professional service rendered in the various political divisions referred to.

MATERNAL AND CHILD HEALTH

Child health services are often initiated by voluntary agencies and later taken over by official agencies. Maternal and child health services of the Commonwealth became a part of the official program of the State Health Department much

later than such definitely legal functions as supervision of water supplies and control of communicable diseases. In Pennsylvania most maternal and child health activities are provided by the State or by local voluntary agencies rather than by local boards of health and local health authorities with the exception of the largest cities.

Much of the program must of necessity be in the field of health education—teaching good health habits, sound nutrition, and the use of community facilities. One of the accepted indices of a good maternal and child health program is the infant and neonatal death rates. Statistics show that the infant death rate dropped from 90 per 1000 live births in 1922 to 32.7 in 1946. The neonatal rate declined also from 41.5 per 1000 live births to 23.7 during the same period and has been practically stationary for the past five years. While this is commendable, the infant death rate in Pennsylvania is higher than such neighboring states as New Jersey, New York, and Delaware. Further reduction will depend upon careful study of the causes of these early infant deaths and efforts to remove them partly through education of physicians and nurses and partly through instruction to expectant mothers with better cooperation between the two groups.

The maternal death rate has also been greatly reduced, but there are several counties in which the rate is still unnecessarily high—3 or over per 1000 live births. There is urgent need to institute measures to reduce this needless loss of life so that the excellent record in some counties may be attained throughout the State.

The maternal and child health program of the Department of Health is directed by the Bureau of Maternal and Child Health. There are five divisions: Preschool, School, Nutrition, Crippled Children, and Rheumatic Fever. Only a small proportion of the budget (15.9 per cent) is derived from state funds and the remainder from the federal Children's Bureau. One of the major functions of the Bureau is operation of child health centers and prenatal clinics throughout the State. These centers and clinics are staffed by part-time physicians. Nurses are provided by the Bureau of Public Health Nursing. There is wide variation in the centers, both in actual practices and in quality of activities. In some instances the services are rated as excellent.

Obviously, the personnel of a well child clinic

must be able to teach and must have a sound knowledge of immunization procedures and of good nutrition and of normal growth.

A study of the data compiled in relation to maternal and child health shows in general that 96 to 98 per cent of mothers reported for prenatal supervision in each county; 80 per cent were delivered in hospitals; over 99 per cent of births were attended by physicians in Luzerne and Westmoreland counties and 97 per cent in Lancaster. Not more than 1 per cent of mothers received their ante-partum care from clinics. Private physicians furnished almost all such care, and all but 5 per cent of mothers registered before the sixth month of pregnancy.

It was interesting to find, too, that less than 4 per cent of the one-year-olds were reported as ever having visited one of the state well child clinics. The survey did not include a review of the child health centers provided by voluntary agencies.

Even though mothers and children are given medical services either in the offices of private physicians or in health centers, the value of home visits by the public health nurse cannot be overestimated. Demonstrations can be given to the mother in familiar surroundings, special problems can be discovered, and stress can be laid on nutrition in all its phases and on promotion of good mental health through sound and practical parent-child relationships.

While maternal and child health services are reasonably well developed in Pennsylvania, further progress could be made through adopting certain recommendations suggested by the survey committee as follows:

1. Establish (through the Advisory Health Board) recognized public health activities in the field of maternal and child health and minimum standards of performance which should be applied to the Bureau's program and to each health jurisdiction or local health unit.

2. Decentralize the direct services of the preschool division and integrate them into the state health districts supervised by district medical directors.

3. Develop adequate medical consultation and supervision services by recruiting young, part-time pediatricians and training them in preventive medicine as it relates to maternal and child health. These pediatricians should receive adequate compensation, but they should meet regular schedules and give conscientious service.

4. Extend consultation service and in-service training to voluntary agencies since they will probably continue to provide much of the service in this field. This might be open to question.

5. Provide mental hygiene services in the Bureau for prevention, consultation, and in-service training.

6. Arrange medical social services to insure the best possible use of the many social agencies concerned with maternal and child health.

7. Develop an active program through committees of local medical societies to study and provide means for reducing maternal and infant deaths. This would include analysis of the causes of prematurity and of epidemic diarrhea of the newborn.

This would require the utmost cooperation of the State Health Department, The Medical Society of the State of Pennsylvania, the hospitals concerned, and other agencies. It has been carried on in Philadelphia since 1941 and should be extended to all parts of the Commonwealth as rapidly as possible.

RUTH H. WEAVER, M.D.,
Division of Medical Services,
Board of Public Education,
Philadelphia, Pa.

OUR NEW FACE

In June, 1897, the first issue of THE PENNSYLVANIA MEDICAL JOURNAL appeared as the successor to the *Pittsburgh Medical Review* which had been in existence eleven years.

It is to the everlasting credit of our predecessors that during all these years the JOURNAL has stood as a champion of the highest principles and the strictest ethics. During half a century its changing corps of editors (5) have never swerved from that original pathway.

This does not mean that changes have not been made. In the beginning THE PENNSYLVANIA MEDICAL JOURNAL contained 48 reading pages; today it averages well over 100 pages. Larger issues and increased publication costs have resulted in the present subscription price of \$5 per year as compared with that of \$2 in the beginning.

More important, however, has been the change in editorial emphasis. Problems confronting the

medical profession today vary from those which it faced at the turn of the century. Their elements then were germs and lack of sanitation. Today they include economics and human relationships born of research in allied sciences. As the battleground spread from the scientific to the sociologic front, THE PENNSYLVANIA MEDICAL JOURNAL took editorial cognizance of that transition.

It was not until 1938 that the style of the JOURNAL was materially changed. At that time a new cover design embodying the use of two colors of ink was inaugurated, as well as many other innovations in type and make-up.

Now, at the beginning of the second half of the twentieth century, the JOURNAL has again taken a new face by adopting a cover design embodying the symbol of our state—the keystone. In addition, the type has been made more legible by allowing additional space between the lines. In order to reproduce the illustrations better and to enhance the readability of each printed message, the text paper has been changed to a process-coated stock.

Throughout the coming year other changes will be made. The publication committee and the editorial staff want to make your JOURNAL serve you, the members of the Society, most effectively. Your suggestions as to what you want your JOURNAL to contain are always welcome.

1950 MEMBERSHIP DUES

To our 8262 members who have paid the 1949 AMA \$25 voluntary assessment, along with 2000 of their fellow members who did not pay, the prospect of paying the required 1950 AMA dues (\$25) may produce entirely different reactions in regard to the 1950 dues.

Those who paid in 1949 are enjoying the satisfaction that comes to those who have helped objectively to make possible the great accomplishments in 1949 of the AMA National Education Campaign. This, President-elect Henderson states, has made "American medicine stronger today than at any time in history, being bulwarked by hundreds of other groups and millions of aroused citizens."

Can one who is intensely interested in the completion of another successful year in 1950 of the AMA National Education Campaign do

better than quote a few 1949 figures from the report of the AMA Coordinating Committee?

During the eleven months ending Nov. 30, 1949, AMA \$25 assessments totaling two and a quarter million dollars were collected, and all but \$200,000 has been spent for printed material, organizational work, and operational expenses.

The headquarters' operating expenses of the AMA in Chicago with its nearly 900 employees approximate \$5,000,000 annually.

The fate of the 1950 AMA education campaign depends upon membership support, on which subject the official publication of the Philadelphia County Medical Society (*Philadelphia Medicine*) of December 17 loyally holds forth as follows under the caption "Let's See It Through!" We quote very briefly:

"The AMA needs more ammunition. If it is to deliver a knockout blow to socialized medicine next year, it must have the finances to continue its program of education which so effectively called a halt on the Federal Administration's attempt to force state medicine upon us in the last Congress.

"This is the first time in the AMA's 102-year history when membership in the Association required the payment of dues of any kind.

"We feel certain that the doctors will meet this new obligation as promptly and generously as they aided the voluntary assessment which enabled the AMA to wage its fight in 1949. All of us have demands made upon our income, but certainly no more important obligation exists than that of helping our parent organization to fight for us against the forces which would destroy free American medicine.

"Let's put our shoulder to the wheel, dig down deep in our pockets, and send our dues through promptly on the first of the year and thereby help the AMA to decisively defeat compulsory health insurance in 1950!"

None of us should feel the slightest embarrassment over the manner in which the money collected in county and state and sent to the AMA is being spent because, as has been quoted before in this publication, in the best American tradition we, the nearly 140,000 members of the AMA, openly, frankly, and honestly thus take our case before the forum of public opinion in our opposition to compulsory sickness insurance. We do this solely to protect the health of the nation. **YOU SHOULD BE PROUD OF THE PART YOU PLAY. ARE YOU?**

SALUTE THE POLICE STATE

From an editorial in the December issue of the *Michigan Medical Journal* devoted to a dis-

cussion of F.B.I. investigations of the AMA, the Michigan State Medical Society, and a score of others, we glean the following evidence:

"That we have gone a long way down the road of police statism is manifested by a consideration of some regulations now in effect. Many of us have sons or daughters and their families in Germany now in connection with the rehabilitation program. Most of them went over under the auspices of the Army, but in the recent reshifting are now under the direct control of the State Department. That program is of great value, and most decidedly needed, but do you know the terms of service in Germany? These young American citizens may write letters home to their families, but those letters cannot be distributed beyond the family; they must not be published or distributed unless they have been censored and approved by the F.B.I. in Germany. We call that a fair degree of police state, and we believe the American people should understand the situation."

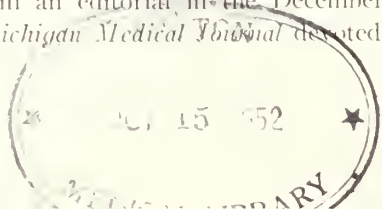
TRY IT

We recently noticed in the *Ohio State Medical Journal* where a physician in southern Ohio had tried a new plan to have his patients read information on medical and health legislation, and apparently the stunt worked. He cleared his waiting room tables of all reading material, magazines, folders, etc., leaving the waiting patient no choice but to read the medical profession's story as told in the various pamphlets he received from his state medical society.

Why not give this idea a trial in your office? Order additional pamphlets on the form appearing on page 87 of this issue.

THE GRIEVANCE COMMITTEE

The problem of professional self-discipline within the medical profession has always been difficult and has been highlighted among criticisms directed toward the medical profession in the past several years. Several state medical associations have attempted to remedy this situation by providing for a statewide committee to hear and investigate complaints made against doctors by the public, thus augmenting the pro-



gram of self-discipline of the county medical societies and assisting the boards of censors of these societies. Such a state committee acts more or less as a grand jury whose function it is to investigate, advise, and prosecute if necessary before the proper judicial body, be it county medical society through the board of censors, the board of councilors of the state association, the board of medical examiners, or a civil court in extreme cases in which such action is deemed justifiable.

The first state medical association to develop such a plan, so far as we are able to discover, was the Colorado State Medical Society. Realizing the need for some more effective means of answering the criticism of the public relative to alleged overcharging and negligence of patients and at times charges of malpractice, the Colorado Society amended its constitution and by-laws to provide for a Board of Supervisors consisting of twelve members of the society, none of whom hold any other office in the state or county societies of which they are members, and with no two members of the board from the same county medical society. This "grand jury" serves in a completely impartial manner made increasingly so by the fact that any member of the board who is a member of the same county society as the doctor under investigation becomes disqualified for any participation on the board in that particular case.

The functions of the Board of Supervisors are as follows:

1. To receive complaints from anyone—doctors, laymen, hospitals, organizations, medical society staff members—about any dissatisfaction in the medical field.
2. To investigate facts in the case.
3. To attempt to mediate the dispute and effect a settlement which is mutually satisfactory to complainant and defendant.
4. To prosecute the case before a proper judicial body if necessary.
5. To carry on a continuous intra-society educational program on medical ethics and patient relations, primarily through personal appearances of board members at county society meetings.

A somewhat similar plan has been established by the Oklahoma State Medical Association in the past year. The group within the state asso-

ciation to which complaints are referred is called the Grievance Committee and consists of the five immediate living past presidents of the association. The objectives and methods of procedure are similar if not the same as those of the Colorado plan, as is true with the plans of the four or more other state medical associations which have followed the lead of Colorado.

The fact that the names of the members of the Grievance Committee are known to the public and that these men are held in high regard and have the confidence of both public and profession because of the lofty position they have previously held in their medical organization produces a feeling of assurance that impartial justice will be had.

The Colorado plan, which has been in operation for two years, and the more recently established Oklahoma plan have both received high praise through editorial comments in the press and by members of the laity and members of the medical profession. Apparently both of these plans have been eminently successful thus far and neither board nor committee has encountered any difficulty it could not cope with satisfactorily.

The majority of complaints received have been due to misunderstandings which have been easily settled by bringing the doctor and the patient together to talk over the difficulty. Often these misunderstandings have been due to failure on the part of the doctor to explain the nature of his charges; the place of laboratory, roentgen-ray, and hospital charges; charges of the anesthesiologists; the cost of drugs; and so forth, which enter into the total cost of a specific illness. It is pointed out that by a little more diligence on the part of the doctors many of these difficulties can be avoided. Some of the types of complaints other than those arising from a belief on the part of the patient that he has been overcharged are the following: unjustified complaints of psychopathic persons or of "dead beats," ungentlemanly conduct of doctors in public, undue familiarity with female patients, public scandals, criminal abortions, unfavorable results from supposedly wrong diagnoses, performance of unjustified surgery, refusal to answer emergency calls, neglect of patients, and malpractice of different kinds.

At the recent clinical session of the American Medical Association held at Washington, D. C., the House of Delegates commended those states that have grievance committees and recommended that all state medical associations which

have not already done so investigate the advisability of forming such committees.

We are indebted to the *Texas State Journal of Medicine* for the above review of the Grievance Committee. The Board of Trustees of The Medical Society of the State of Pennsylvania on December 8 authorized the chairman of the Board to appoint a committee to study the different grievance committee plans and to report back at the March meeting of the Board. The chairman of the Board of Trustees, Dr. George S. Klump, named the following committee to study this problem: Drs. Louis W. Jones, Wilkes-Barre, chairman; James E. Appel, Lancaster; Walter F. Donaldson, Pittsburgh; and Howard K. Petry, Harrisburg.

The Board of Trustees further provided that the secretaries and presidents of county medical societies be advised that such a committee is making this study and the Board suggests that in the interim the county societies refer such lay grievances to their county board of censors for hearing.

ELECTROCARDIOGRAPHY COURSE TO BE REPEATED

With the great scientific advances which are being made every day in the field of medicine, one continually wonders how the medical practitioner is capable of paralleling this advance with a similar advance in personal knowledge and technique. The question also arises as to the form in which such scientific advances can best be presented to the profession.

The answer is not easy, but a partial explanation may be gleaned from the results of a very little publicized course in electrocardiography arranged by our own Commission on Graduate Education.

Almost two months in advance of the first scheduled lecture the maximum number of sixty registrations was received through a brief notice placed in the program of the third annual Graduate Education Institute. Naturally, all further planned publicity was eliminated immediately, and yet more applications continued to be submitted. Such response necessitated making plans for repeating the course in the spring of 1950.

This special course in electrocardiography will

again be presented in the Harrisburg Hospital on Thursdays, May 11, 18, 25 and June 1, 8, 15 and 22, 1950. A registration fee of \$35.00 is required and those who intend to register should do so at once. The course has again been limited to sixty and, with over thirty applications left over from the fall course, only those who fill out the form on page 53 early can be accepted.

It is gratifying to note that county society members are enrolled from as far east as Philadelphia, north to Mansfield, and west to Indiana. With the better weather prevailing in the spring of the year, registrations are expected from physicians located at even further distances.

The faculty for this second course is the same group of physicians who successfully taught the fall course. Headed by Thomas M. Durant, professor of clinical medicine at Temple University School of Medicine, the faculty also includes Constantine P. Faller, cardiologist, Harrisburg Hospital, Harrisburg; John B. Levan, chief of Cardiac Clinic, St. Joseph's Hospital, Reading; Kenneth E. Quickel, associate in medicine, Harrisburg Hospital, Harrisburg; and Charles Wm. Smith, associate in medicine, Harrisburg Hospital, Harrisburg.

For the further information of those desiring to avail themselves of this practical course in electrocardiography, the outline of the program by days is printed below.

PROGRAM

May 11—The limitations of the electrocardiogram. Discussion of the anatomy, physiology, the pathway of the impulse, and pharmacology. Description of instruments and the galvanometer. The fundamental considerations of electrical phenomena.

May 18—The effect of a single cell on the three leads. The heart as a polarized cell. Description of the normal electrocardiogram. Development of the normal electrocardiogram and the showing of normal tracings.

May 25—Explanation of technique, artefacts, precordial leads, unipolar limb leads, abnormal P waves and PR interval. The axis deviation on ventricular strain patterns and a study of tracings.

June 1—A discussion of the arrhythmias and the bundle branch block followed by a study of tracings.

June 8—The entire day will be devoted to a discussion of myocardial infarction and the study of tracings.

June 15—Exploration of the effects of drugs and ions on electrocardiograms. A discussion of the pre-excitation phenomena, the ventricular gradient, and the electrocardiogram in rheumatic fever—each of these to be followed by a study of tracings.

June 22—A study of electrocardiographic changes in diseases followed by a discussion of pericarditis and the limitations of electrocardiography.

Announcing

Special Electrocardiography Course

Nurses' Auditorium, Harrisburg Hospital, Harrisburg

To be presented on seven consecutive Thursdays from 9 a.m. to 4:30 p.m.

May 11, 18, 25, June 1, 8, 15, and 22, 1950

Registration fee \$35.00 - Registrations limited to 60

42 Hours of Intensive Instruction

Presented by the Commission on Graduate Education of

The Medical Society of the State of Pennsylvania

Enroll now before the quota is filled—use the form below

Special Electrocardiography Course Registration Form

TO THE COMMISSION ON GRADUATE EDUCATION,
230 State St., Harrisburg, Pa.

Please enroll me in the Electrocardiography Course to be given in the Nurses' Auditorium of the Harrisburg Hospital, Harrisburg, on Thursdays, May 11, 18, 25, June 1, 8, 15, and 22, 1950.

I am enclosing my check for \$35.00 made payable to The Medical Society of the State of Pennsylvania for my registration fee.

Name (print in full)

Street

City

Specialty (if any)

Signed

, M.D.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

New Film Available

The second in a series of medical films sponsored by the Professional Education Section of the American Cancer Society has just been released and through state medical societies and state departments of health is being made available to physicians throughout the country. It is available already for showing to physicians in Pennsylvania.

The new film, entitled "Breast Cancer: The Problem of Early Diagnosis," was previewed recently in Washington, D. C., at the Interim Session of the American Medical Association where it received enthusiastic response from both the audience and the press.

The Pennsylvania Division of the American Cancer Society has just turned over to The Medical Society of the State of Pennsylvania one print of this film. It was placed in the Medical Society's film library, along with other films on cancer, where it may be obtained on a loan basis for showings to professional audiences throughout the Commonwealth.

The new reel is said to be equal in quality and teaching value to the first in the series of medical films, "Cancer: The Problem of Early Diagnosis," which was released several months ago and which still is available from the Medical Society's film library. All films are being prepared with the full cooperation of the National Cancer Institute.

"Cancer: The Problem of Early Diagnosis" was awarded first prize—a silver medal—in the Medicine and Natural Science group at the Tenth International Exhibition of Cinematographic Art held at Venice in August, indicating the educational value and high caliber of the motion picture.

The award was made November 21 by the Italian Embassy at a ceremony at the Department of State. It was accepted by Dr. John R. Heller, Jr., on behalf of the National Cancer Institute, and Dr. Charles S. Cameron, medical and scientific director and vice-president of the American Cancer Society.

Exfoliative Cytology Courses

Two courses of training in exfoliative cytology will be given at Cornell University Medical College under the direction of Dr. George N. Papanicolaou with the active cooperation of members of his staff.

The first course will be held from March 20 to April 1 and will be for laboratory technicians. The purpose of the course will be to familiarize technicians with the methods of preparing and staining smears of various body fluids and to give them instruction in the principles of screening such smears. Applications will be considered only from qualified technicians employed by a hospital or laboratory where this technique is in use or is expected to be used. The tuition is \$100 and all inquiries should be directed to Miss Charlotte M. Street, Cornell University Medical College, 1300 York Ave., New York 21, N. Y.

The second course from April 17 to April 29 will be for physicians. Like the first course, it will be under the direction of Dr. Papanicolaou and will include lectures, discussions, demonstration of slides, and study of representative smears from various fluids. The tuition is \$100 and inquiries may be directed to Dr. Papanicolaou at Cornell University Medical School, 1300 York Ave., New York 21, N. Y.

The American Cancer Society considers payment of tuitions for these courses as a justified and sound expenditure by its local units to encourage professional education and the knowledge of cancer among professional persons.

Conference on Cancer Detection

Proceedings of the Conference on Cancer Detection have been prepared by the American Cancer Society and are being made available to all interested physicians through the Pennsylvania Division. The conference was held at Portsmouth, N. H., last fall when many persons prominent in the cancer field appeared on the program. Copies of the proceedings are being sent to all conference participants, medical school libraries, and state medical societies.

Principles of Medical Ethics of the American Medical Association

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's *Principles of Ethics*, 1803.)

CHAPTER I

General Principles

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning

cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATIONAL INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions

* Sir Thomas Watson.

from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered to the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

Duties of Physicians to Their Patients

STANDARDS, USEFULNESS, NONSECTARIANISM

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

* Nicoll, father of Galen.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

Duties of Physicians to Each Other and to the Profession at Large

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III—DUTIES OF PHYSICIANS IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the phy-

sician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS
ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident,

sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

The Duties of Physicians to the Public

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of

the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

SOUND PUBLIC RELATIONS



Dr. Lewis T. Buckman, speaker of the MSSP House of Delegates, graphically portrays "The Doctor" at the kick-off dinner of Wyoming Valley's 1949 Community Chest Campaign. The picture, housed in a trailer body, was spectacular in its effect and won the prize of \$500, later turned over to the Community Chest. Characters in the portrait, left to right, are Dr. Buckman, Jonnelle Carey, Dr. Samuel T. Buckman, and Mrs. Edward W. Bixby. Mrs. Bixby is a member of the board of the Woman's Auxiliary to the Luzerne County Medical Society and worked with the doctors' division of the campaign. Standing by the exhibit in surgical gowns are: Drs. Jacob G. Hyman, Gerald N. Fluegel, Max Tischler, Frank M. Pugliese, Herman B. Popkey, and Edward W. Bixby. Several other doctors and their wives aided in the campaign, among them Mrs. Charles L. Shafer who headed the house-to-house drive in Kingston.

APPLICATIONS NOW IN ORDER

Funds from the Educational Fund of The Medical Society of the State of Pennsylvania are now available for children of a member who, through death or incapacitating illness or injury of the parent, are in need of financial assistance and can qualify satisfactorily for college entrance. A copy of the application form appeared in the December issue of THE PENNSYLVANIA MEDICAL JOURNAL, page 1734.

Copies of the form may be had by writing to the Educational Fund Committee, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

Applications for the school year beginning in September must be received before April 1.

Those who are not familiar with the purposes of the fund or its administration may find complete information in the appended quotations from the Constitution and By-laws of the State Society.

Constitution—Article IX, Section 5

Each year out of the funds of this Society, the trustees and councilors with the approval of the House of Delegates may appropriate a sum not to exceed \$2.00 for each active member to be set aside by the Secretary-Treasurer as a special fund to be known as an Educational Fund. This fund shall be kept separate from other funds, and may be invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors, and shall be used to assist in the underwriting of the expenses of continuing the education in high school, college, or medical school of the children of members of this Society if and when said training is about to be discontinued for lack of family financial support following the death, or incapacitating illness, or injury of the physician parent member of this Society.

By-Laws—Chapter VII, Section 9

The Committee on Educational Fund shall consist of the Secretary-Treasurer and three members to be selected annually by the Trustees and Councilors, at least one of whom shall be a Trustee and Councilor. This committee shall select its own chairman, secretary, and treasurer, and shall have jurisdiction over the distribution of such part of the Educational Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary of the committee, and an annual audit of its accounts shall be made by a committee of the Trustees and Councilors. When considering requests for educational assistance, this committee shall consult members of the component society of the county from which the request is received and shall consult also teachers and pertinent school records in their efforts to determine (1) the need for financial assistance and (2) the qualifications for the absorption of higher education of those for whom assistance is sought. This committee may

solicit donations, legacies, and repayments to be added to the Educational Fund. All expense for the administration of this fund shall be met from the Society's general checking account.

LOW LEVEL OF SOVIET MEDICINE ATTRIBUTED TO SHACKLING OF DOCTORS

The low level of medical care in the Soviet Union results from restraints on doctors says an editorial in the *Journal of the American Medical Association*.

"Unfortunately for Soviet citizens, Soviet medicine does not appear to be as good as Soviet propaganda," the editorial points out.

"In fact, few factual data may be found published concerning the quality of Soviet medicine. Most evaluations outside the U.S.S.R. are based on observations of foreigners who have been in the country and on the reports of Soviet refugees.

"However, on rare occasions frank articles have appeared in Soviet periodicals. When the boasting is discounted and the facts critically examined, these articles reveal a disturbing state of affairs.

"Official statements said to be attributed to a Minister of Public Health revealed shortages of equipment in every medical field. Drugs were often claimed to be of poor quality, and their faulty distribution is said to have caused serious shortages. Medical clinics and institutions have increased in recent years, but rural areas, it is said, still are lacking even minimum medical care and large areas are practically without facilities for surgery.

"Physicians and nurses are reported to be poorly trained and to have few opportunities to specialize. Even the former Minister of Health admitted in some instances 50 to 75 per cent error in diagnosis, which, if true, is a sad reflection on the care available to the Soviet citizen.

"Apparently opportunities for advanced training and for personal advancement are hampered also by a shortage and the inadequate quality of medical publications and a limited circulation of those that are published. The ministry probably publishes fewer than thirty journals and only one, *Soviet Medicine*, is suited to the majority of practitioners. However, even the Minister of Health once admitted that few articles in *Soviet Medicine* were of interest to doctors.

"The former Soviet Minister of Public Health perhaps unknowingly revealed one of the basic reasons for the present level of Soviet medicine when he wrote that praise by the people of the Soviet Union is the highest possible honor and that attempts of Soviet scientists to gain recognition elsewhere lowered the honor and authority of these researchers.

"He warned, 'We shall have to help these scientists free themselves from this psychopathy and bootlicking of foreign things.' In the face of such twisted thinking Soviet physicians and researchers have limited opportunity to improve their lot and the health of the people in their country."

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*
8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

38TH ANNUAL SECRETARIES-EDITORS CONFERENCE

(None held 1940-44)

To Component County Medical Society Secretaries, Editors, Presidents, Presidents-elect, and their respective 1950 Chairmen of Committees on Public Health Legislation, Public Relations, and Medical Economics:

The thirty-eighth annual Secretaries-Editors Conference will be held in the Penn-Harris Hotel, Harrisburg, on Thursday afternoon and evening, March 2, and continued on Friday morning, March 3, 1950.

The Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania, as always, recognizing the great potentialities of these winter meetings, has provided sufficient funds to pay the reasonable travel and hotel expense of the above-mentioned four to seven designated representatives of each of our sixty county medical societies.

Post cards have been mailed for the purpose of making early hotel reservations for Thursday night, March 2, and for the Thursday evening dinner. To be assured of comfortable accommodations, please make reservations promptly and, if possible, anticipate two from the same county society occupying a double room.

This year's program will be stimulatingly instructive with opportunity for sociability and expansion of acquaintanceship. There will be fewer papers than in former years, but increased audience participation is planned with dramatization interspersed. All features of the afternoon, evening, and morning sessions will be pointed toward giving those in attendance increased fervor in behalf of individual participation by every State Society member in accomplishing the stated purposes of our organizations—county, state, and AMA.

WALTER F. DONALDSON,
Secretary-Treasurer.

1949 AMA ASSESSMENT

The December issue of the JOURNAL, page 1730, listed by counties on a percentage basis the number of active members who had paid the 1949 AMA assessment up to December 16.

As of Jan. 18, 1950, additional county society members who had paid the assessment totaled 77, divided as follows:

Philadelphia	18
Allegheny	10
Lackawanna	9
Erie, Luzerne	6 each
Montour	5
Mercer	4
Delaware, Lehigh,	}
Lycoming, Montgomery,	
Schuylkill	2 each
Beaver, Cambria, Chester,	}
Fayette, Franklin,	
McKean, Monroe, Venango	1 each

The above figures serve to increase December percentages to the following:

Mercer to 94%, Erie to 88%, Montgomery to 86%, Montour to 85%, Fayette and Lycoming to 84%, Allegheny to 83%, Venango to 76%, Philadelphia, Lackawanna, and Delaware to 72%, Luzerne to 68%, Monroe to 66%, and Schuylkill to 62%.

The final figures will be published in the February JOURNAL.

A PENNSYLVANIA DIPLOMA MILL

The *Philadelphia Inquirer*, during the latter part of December, in a series of special articles exposed the sale of fraudulent diplomas under such headlines as:

"Diploma Peddler Slams Door on Troopers, Flees Arrest on New Charges"

"Fake Chiropractors Paid State Employee \$1,200 in Scheme to Get Licenses—Some Bought Diplomas from 'Mill'"

"Chiropractors Charge Slush Fund Purchased Licenses for 50 in State"

"Money Spent on Politicians and 'Refresher Courses,' Probers Will Be Informed"

"Two on Chiropractic Board Practicing Without License"

"Now Ban All Unlicensed Practitioners"

"The *Inquirer* offers a reward of \$1,000 for positive evidence of the identity of the politician or public officeholder or holders who protected Daniel J. McDevitt in the sale of fraudulent diplomas."

It was said that McDevitt operated a string of unlicensed schools of nursing, physiotherapy, and massage, as well as chiropractic, and is now under bail of \$2,500 on charges of fraud and forgery.

On December 17 the *Inquirer* quoted Deputy Attorney General Abraham J. Levy as stating that "state police were broadening the investigation to check unlicensed chiropractors and physicians throughout the State to uncover holders of fraudulent diplomas"; further that "Earl A. Irvine, an operative for the Globe International Detective Agency, testified that he contacted McDevitt last July. He said that for \$100 he purchased a doctor of chiropractic diploma in the name of his nephew, Raymond Irvine, a dental student at Temple University.

Next a Medical Diploma

"Irvine also produced a doctor of philosophy certificate, which he said he had purchased from McDevitt, as well as a medical diploma from the Kansas City University of Physicians and Surgeons, an attendance certificate showing credits from the same institution, and a Kappa Phi Sigma medical fraternity scroll.

"Irvine said he gave McDevitt \$200, got the address of the New Jersey place, and obtained a medical diploma, ostensibly issued by the Kansas City University. Irvine said he returned to McDevitt's office and complained that the seal was lacking. The detective said that McDevitt then placed the gold seal of the Kansas City school on the diploma and gave it to him.

"State Patrolmen James F. Updyke and Maurice F. Wilhere, who made the arrest, said that the \$200 identified by Irvine—consisting of twenty \$10 bills—was found in McDevitt's possession. Wilhere said that McDevitt admitted he had received the money from Irvine."

It will be remembered that the 1949 Pennsylvania Legislature, which created the Pennsylvania Chiropractic Board of Licensure, also created a legislative fact-finding agency known as the Joint State Government Commission, with ample authority to make such an investigation as is pointedly suggested by the findings above related and given full publicity by the *Philadelphia Inquirer*.—*Pittsburgh Medical Bulletin*.

PRACTICE OF MULTIPLE APPLICATIONS

From an article appearing in the November, 1949 *Journal of the Association of American Medical Colleges*, we quote briefly from a "Study of Applicants for Admission to U. S. Medical Colleges—Entering Class of September, 1948."

In 1948 there was a total of 24,242 applicants who made a total of 81,662 applications (an all-time high*) to 71 four-year medical schools and the 8 two-year schools of basic medical science of the United States.

Six states (New York, Pennsylvania, California, Illinois, Ohio, and Texas) provided 45 per cent of the applicants. Areas outside the United States provided only about 3 per cent of the applicants.

Fortunately, 10,784 students elected to apply at only one medical school; of the next 10,125 students an average of 2027 made application to 5 medical schools, while the final 3333 students made multiple applications ranging from 539 who applied to 7 medical schools all the way down to two students who applied to 39 schools. A total of 224 made application to 20 or more medical schools.

Of the grand total of 24,242 applicants, 6973 received acceptances as follows:

6141 applicants	received 1 acceptance
679 applicants	received 2 acceptances
125 applicants	received 3 acceptances
21 applicants	received 4 acceptances
6 applicants	received 5 acceptances
1 applicant	received 8 acceptances

The relatively large number of multiple acceptances led to the association's recently inaugurating the plan for distributing fortnightly to

* The comparable figure for 1947 was 56,553; the number of applicants reported for the entering class of 1938 was 36,268.

all schools the names of applicants who have been accepted at any school.

In 1948 medical schools in the Keystone State reported applications as follows:

	<i>Accepted Rejected</i>	
Woman's Medical College of Pennsylvania	70	264
University of Pittsburgh School of Medicine	97	822
Hahnemann Medical College and Hospital	123	1258
Jefferson Medical College of Philadelphia	148	1586
University of Pennsylvania School of Medicine	187	2664
Temple University School of Medicine	146	3056

Dean F. Smiley, M.D., and Virginia Zaleski of the Association of American Medical Colleges made the study from which this compilation is made.

QUACKERY NEVER CRUSHED TO EARTH

An extensive review of the book *Diabetes and Its Treatment*, by Joseph H. Barach, M.D., of Pittsburgh, appears in the December 15 issue of the *New England Medical Journal*. The reviewer states that the volume is decidedly Dr. Barach's very own and notes that "commendable initiative throughout is shown by the writer. Throughout the volume one finds words of wisdom and new viewpoints when old problems are presented. There is an instructive table of the common complaints of the patient and a novel discussion of weights and diets."

The reviewer, agreeing heartily with Dr. Barach on the detail of "obesity," takes issue with him on "heredity." We quote: "The following statement about obesity is worth wide dissemination: 'Since there is no known advantage in being overweight, we may very well offer the blanket advice to everyone to avoid obesity.' In dealing with heredity, however, the author inadvertently has given a wrong impression in stating that all the children of two diabetic parents will develop diabetes. Theoretically, they will develop diabetes, but practically they will not do so unless they live long enough to reach the age at which diabetes is likely to break out. The chances have been computed that before

those ages are reached at least half the offspring will die of other diseases."

The reviewer gives great credit to Dr. Barach for activities very familiar to western Pennsylvanians, namely, "his courage in exposing diabetic quackery wherever found."

The day the above comments were written there came to the Editor's desk from an alert physician in northeastern Pennsylvania the following classified advertisement clipped from the Stroudsburg (Pa.) *Daily Record*:

"Diabetes patients cured at home. Buy health for holidays. Write *Daily Record*, Box 67."

This shows that quackery is never completely crushed to earth, but continues to demand, on occasion, outspoken condemnation by the medical profession and decisive police action at local as well as state and federal levels.

HOME COUNTY RECOGNITION

From the Lycoming County Medical Society *Bulletin* for December, it is learned that the society, in complimenting Dr. George S. Klump on his long and brilliant service as councilor and trustee of the State Society (currently chairman), presented him recently with an "engraved note folder" and recounted the magnitude of his sacrifices and the Lycoming County Society's indebtedness to him.

BRITISH COSTS UP 400 PER CENT

Only one-seventh of the annual cost of the British Health Service is paid by contributions from workers and employers. The balance is paid out of taxes, which in income taxes alone now amount to 45 cents out of every dollar a poor man earns and 97.5 cents out of every dollar a rich man acquires.

In addition, there are indirect taxes, sales taxes, and profit taxes on the balance.

When the National Health Bill was introduced, the estimate of the British first year's cost from general taxes, beyond worker-employer contributions, was \$2,660,000,000 at the devalued rate of exchange.

In February, 1949, after the system had been

BOSTON

OCT 15 1952

operating for seven months, this estimate was boosted to \$5,648,000,000 for nine months.

For the twelve months the estimated total cost of the system from general taxes plus contributions is estimated by officials at \$9,856,000,000.—
EXCHANGE.

AMA MEMBERSHIP CLARIFIED

To the Secretaries of the Constituent State and Territorial Medical Associations:

The House of Delegates of the American Medical Association at its meeting in Washington, D. C., Dec. 6 to 8, 1949, adopted amendments to the By-Laws of the American Medical Association whereby Division One, Chapter II, Tenure of Membership, has been changed to read as follows:

Chapter II—Tenure and Obligations of Membership; Dues

SECTION 1.—When the Secretary is officially informed that a member is not in good standing in his component society he shall remove the name of said member from the membership roll. A member shall hold his membership through the constituent association in the jurisdiction of which he practices. Should he remove his practice to another jurisdiction, he shall apply for membership through the constituent association in the jurisdiction to which he has moved his practice. Unless he has transferred his membership within six months after such change of practice, the Secretary shall remove his name from the roster of members.

SECTION 2.—Annual dues, not to exceed \$25.00, may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

An active member who is delinquent in the payment of such dues for one year shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

Any former member who has forfeited his membership because of being delinquent in payment of dues may be reinstated on payment of his indebtedness.

You will note that the following important changes have been made:

(A) The word "Dues" has been added to the title of Chapter II.

(B) Chapter II has been divided into two sections.

(C) The first sentence of Chapter II, which read "Membership in this Association shall continue as long as a physician is a member of a component society of

the constituent association through which he holds membership," has been deleted.

(D) The words "of the American Medical Association" have been added after the word "Secretary" where clarification is necessary.

(E) The sentence, "An active member shall pay dues or assessments as may be prescribed by the Constitution or By-Laws," has been deleted.

(F) The words "in the American Medical Association" have been added after the words "shall forfeit his active membership" in the second paragraph of Section 2.

(G) The sentence forming the third paragraph of Section 2, with regard to reinstatement, is a new addition to Chapter II.

(H) A new paragraph, forming the first paragraph of Section 2, providing for annual dues not to exceed \$25.00 has been added to Chapter II.

The House of Delegates, on recommendation of the Board of Trustees, set the membership dues for the year 1950 at \$25.00.

The full effect of the new provisions will have to be studied and developed during the next year. However, the following interpretations of the amended By-Laws are offered for your guidance at this time:

(a) Active membership in the American Medical Association will continue to be limited to those members of constituent associations who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) are entitled to exercise the rights of active membership in their constituent associations as provided in Article 5 of the Constitution of the American Medical Association.

(b) A member of the American Medical Association shall lose his membership in the Association when the Secretary of the American Medical Association is officially informed that a member is not in good standing in his component society *or is delinquent in the payment of the American Medical Association dues established by the above change in the By-Laws.*

(c) Forfeiture of membership in the American Medical Association due to failure to pay dues will have no effect on membership in the component or constituent medical societies unless the component or constituent societies amend their respective constitutions and by-laws. It is, therefore, possible that a physician may be a member of his component and constituent societies and at the same time not be a member of the American Medical Association.

(d) The amended By-Laws provide for the collection of the American Medical Association membership dues by the constituent associations for transmittal to the Secretary of the American Medical Association. The detailed method to be adopted by each constituent association will vary in each state. In general, the method utilized by each state for the collection of its own component and constituent association dues should be followed.

Some of the problems involved in the collection and transmittal of dues will be considered in a later communication to you.

It is planned to provide each member of the American Medical Association a membership card and certificate of membership when his dues are paid.

It will be necessary for the Secretary of the American Medical Association to notify those members who are delinquent in the payment of their dues, and this office will, therefore, require a complete list of all active dues-paying members.

No changes have been made in the Constitution and By-Laws of the American Medical Association with respect to Fellowship. Eligibility for Fellowship and annual Fellowship dues of \$12.00 remain the same. Under the present By-Laws a Fellow will pay for the year 1950 total membership and Fellowship dues of \$37.00.

The following members may be exempted from the payment of the \$25.00 American Medical Association membership dues: retired members; members who are physically disabled; interns; and those members for whom the payment of such dues would constitute a financial hardship.

No member should be exempted from the payment of his American Medical Association dues who is not exempted from his component and constituent society dues.

GEORGE F. LULL, *Secretary,*
American Medical Association,
Chicago, Ill.

Dec. 15, 1949

EXCERPTS FROM AMA SECRETARY'S LETTER

Dr. James F. Norton, president of the Medical Society of New Jersey and vice-president of the American Medical Association; Dr. Francis F. Borzell, Philadelphia, speaker of the AMA House of Delegates, and John L. Bach, director of AMA Press Relations, were among the 12 panel members who took part in the first state-wide medical press conference sponsored by the Medical Society of New Jersey in Trenton, November 18. More than 100 newspapermen from every part of New Jersey attended the conference, which was arranged by James E. Bryan, executive officer of the state medical society.

The meeting marked the sixth such conference sponsored by state medical societies throughout the country during the last year in an effort to create a better working partnership between newspapermen and the medical profession.

Like previous conferences in other parts of the country, the New Jersey meeting was highly successful, and Dr. Luke A. Mulligan, chairman of the public relations committee of the state medical society, said "the session marked the turning point for a better understanding between the journalistic and medical professions."

Mr. Bach said that the medical profession and newspapers were adrift in the same boat, adding:

"The anti-trust division of the Department of Justice is presently digging into the records of the AMA and 22 component medical societies to see if any monopoly exists in connection with prepaid medical care plans.

"It was only recently," Mr. Bach continued, "that one newspaper—the Lorain, Ohio, *Journal*—was made the target in a suit filed by the anti-trust division of the Department of Justice in the federal court in Cleveland. The suit is a threat to the rights of every newspaper and publication in the United States.

"The government is asking for the power to force the Lorain *Journal* to accept the advertisement of any advertiser, the publication of which would not constitute a violation of state or federal laws.

"It goes without saying that the use of any such power would not be limited by the government to the Lorain *Journal*. It would apply to all newspapers, magazines, and periodicals of general circulation.

"If the government is successful in this first attempt to regulate the advertising practices of a newspaper, all newspapers become subject to its scrutiny and control. If advertising content can be regulated under the common carrier classification, then advertising rates can be government-supervised. And after rates and advertising content come editorial content, once the precedent has been established and the government has its foot in the door. . . .

Dr. Irons Addresses Southern Medical. Labor leaders are beginning to realize that socialized medicine is a threat to the continued existence of unions, AMA President Ernest E. Irons said last week in addressing the Southern Medical Association meeting in Cincinnati.

"Until recently labor leaders thought they saw in nationalized medicine a potent help in their labor programs," Dr. Irons said, adding: "Labor unions were told that support of administration measures was to their advantage and was imperative.

"Now, as the picture unfolds, it becomes evident that among the first victims of nationalized medicine would be the unions' own health services. Later, the unions themselves will be destroyed along with business firms in the progressive strangling of free enterprise by the enveloping socialist state.

"English labor unions already have felt the increasing restrictions of a Socialist government. In the propaganda for nationalized medicine in America, union members have been told that this could not happen. A considerable degree of finesse and some time will now be required here by understanding labor leaders to disabuse the minds of their followers of this socialist deception."

Hygeia Used in School Study Plan.—*Hygeia*, the health magazine of the American Medical Association, is being used in a group health study plan by an increasing number of schools. The study plan is based on *Hygeia* articles and the discussion topics are prepared by the staff of the health and fitness division of the AMA Bureau of Health Education.

National Society for Crippled Children Has Excellent Meeting.—Past President R. L. Sensenich, of South Bend, and I attended the recent annual convention of

the National Society for Crippled Children and Adults in New York. Representatives from the society's 2000 state and local affiliates throughout the United States, Alaska, and Hawaii heard prominent authorities tell of the achievements being made in the rehabilitation of the physically and mentally handicapped.

The way the convention sessions moved along indicated careful planning in advance, and the high caliber of papers and demonstrations made it evident to all who attended that excellent progress is being made in the improvement of the handicapped—much more than the average person realizes. One full day of the five-day meeting was devoted to problems of cerebral palsy.

Discontinue AMA Network Broadcasts.—The AMA Bureau of Health Education has decided to discontinue its radio network series during the next year and turn its resources to servicing state and local medical societies with radio programs for broadcasting in their areas. As a result, a larger number of recorded series will be made available to state societies during the next year.

Medical Education Survey.—After a year and a half of planning, the Medical Education Survey, sponsored by the AMA Council on Medical Education and Hospitals and the Association of American Medical Colleges, was initiated this fall. Six medical schools already have been visited and it is hoped that the remainder will be seen during the next two academic years.

In addition to a study of undergraduate medical education, the survey also will be concerned with premedical education and with graduate and postgraduate education and the relationships of the medical schools to the community.

At the conclusion of the study, the survey committee will prepare and publish a comprehensive report of its findings and recommendations.

Committee to Make AMA Study in England.—Two members of a committee of three—Dr. Loren R. Chandler, San Francisco, dean of Stanford University School of Medicine, and Dr. Harold Diehl, Minneapolis, dean of medical sciences, University of Minnesota—left recently for England to make a study of medical education as it now exists under health legislation initiated by the Labor government. The third member of the committee—Dr. Stanley Dorst, Cincinnati, dean of the University of Cincinnati College of Medicine—will leave soon and join the others in London.

The committee is making the study on behalf of the AMA, and its report will be made to the Board of Trustees.

A second group, consisting of a surgeon, internist, general practitioner, pediatrician, and an industrial physician, is expected to go to England soon to make a factual study for the AMA of the effect of the health act on the people of that country. This group also will make its report to the Board of Trustees. The report will cover the broad aspects of medical care under the socialistic scheme in England.

GEORGE F. LULL, M.D.,
Secretary and General Manager.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since November 1. Figures in first column denote county society numbers; second column, State Society numbers.

Nov. 1	Mifflin	38-39	10694-10695	\$15.00
	Allegheny	1651-1652	10696-10697	15.00
	Adams	29	10698	7.50
	Clinton	28	10699	7.50
2	Chester	122	10700	7.50
	Philadelphia	3214-3239	10701-10726	202.50
	Fayette	120	10727	15.00
	Delaware	304	10728	15.00
7	Chester	123	10729	15.00
9	Westmoreland	218	10730	7.50
22	Jefferson	62	10731	7.50
	Washington	150-152	10732-10734	37.50
23	Delaware	305	10735	15.00
	Blair	128-130	10736-10738	30.00

CHANGES IN MEMBERSHIP

New (28) and Reinstated (5) Members

ADAMS COUNTY: John C. Menges, Adamstown.

BLAIR COUNTY: Robert J. Hill and James M. O'Leary, Altoona. (Reinstated) Daniel M. Repogle, Altoona.

CHESTER COUNTY: Richard H. Bolster, Berwyn. (R) Max Cohen, Coatesville.

CLINTON COUNTY: David W. Thomas, Jr., Lock Haven.

DELAWARE COUNTY: (R) John K. Finley, Chester.

FAVETTE COUNTY: (R) Stephen Andolina, Dunbar.

JEFFERSON COUNTY: George A. Picard, Punxsutawney.

LUZERNE COUNTY: Arthur S. Ninomiya, Coaldale.

PHILADELPHIA COUNTY: Gladstone W. Allen, John F. Ambrose, Jr., Francis J. Fazio, Eugene A. Hargrove, John J. Joyce, Raymond S. Leopold, Edward R. Lucente, Douglas B. Nagle, William H. Pfeffer, George P. Pilling, 3d, Edgar L. Ralston, Harry N. Rasansky, Paul J. Salvo, David S. Smith, and Louise Zibold, Philadelphia; John H. Kolmer, Bala; George C. Lewis, Jr., and Mario V. Troncelliti, Ardmore. (R) John O. Bower, Philadelphia.

WASHINGTON COUNTY: Donald T. Blatchley and Howard H. MacDougall, Washington.

WESTMORELAND COUNTY: Edwin K. Vey, New Kensington.

Resignations (5), Transfers (10), Deaths (16)

ALLEGHENY: *Resignations*—Robert A. Clark, Victor P. Cafaro, Darrell W. Whitaker, and Emanuel Berger, Pittsburgh. *Death*—James C. Fleming, Pittsburgh (Univ. Pgh. '10), November 13, aged 65.

BEAVER: *Death*—Raymond L. Sheets, Beaver Falls (Hahn. Med. Coll. '20), November 7, aged 57.

CARBON: *Transfer*—Homer B. Fegley, Lehighton, from Lehigh County Society.

CUMBERLAND: *Death*—James C. Cochran, Carlisle (Jeff. Med. Coll. '39), November 1, aged 35.

DELAWARE: *Transfer*—Ruth Garner Goynes, Sharon Hill, from Washington County Society.

ERIE: *Transfers*—Anna Mary Booth and Wilfred F. Heinbach, Jr., Erie, from Northumberland County Society.

FAYETTE: *Transfer*—Stephen Andolina, Dunbar, from Allegheny County Society.

LACKAWANNA: *Transfer*—Edward A. Kowalyk, Clarks Summit, from Montour County Society. *Death*—Addison W. Smith, Fort Madison, Iowa (Jeff. Med. Coll. '91), November 9, aged 82.

LUZERNE: *Death*—John J. Corrigan, Hazleton (Jeff. Med. Coll. '96), November 12, aged 79.

McKEAN: *Death*—Bernard S. Bretherick, Port Allegany (Hahn. Med. Coll. '31), November 9, aged 43.

MONTGOMERY: *Transfer*—Clarkson Wentz, Phoenixville, from Philadelphia County Society. *Death*—Clarence E. Apple, Philadelphia (Jeff. Med. Coll. '04), October 22, aged 67.

NORTHAMPTON: *Transfer*—George M. Knoll, Bethlehem, from Philadelphia County Society.

PHILADELPHIA: *Transfers*—Rowland Ricketts, Norton, Va., to Wise County (Va.) Medical Society; George R. Wade, Moorestown, N. J., to Burlington County (N. J.) Medical Society. *Resignation*—John Edwin James, Jr., Mt. Dora, Fla. *Deaths*—Cunningham P. Clark, Cool Spring, Del. (Jeff. Med. Coll. '95), November 11, aged 77; Harry Keyser Carey, Philadelphia (Univ. Pa. '98), October 31, aged 73; Paul N. Jepson, Philadelphia (Univ. Pa. '20), October 24, aged 56; Henry D. Jump, Philadelphia (Univ. Pa. '93), November 17, aged 82; Arthur P. Keegan, Philadelphia (Med.-Chi. Coll. '13), November 22, aged 63; A. Victor Pelosi, Philadelphia (Temple Univ. '26), October 26, aged 50; George Jacob Schwartz, Philadelphia (Med.-Chi. Coll. '99), November 22, aged 72; Hervey B. Weiss, Philadelphia (Jeff. Med. Coll. '01), October 17, aged 73.

TIOGA: *Death*—William Bache, Jr., Wellsboro (Jeff. Med. Coll. '27), October 24, aged 50.

prints and tear sheets from current periodicals filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948, an increase of 293 requests over the total for 1947.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Requests filed during the month of November were:

Use of dextran	Cysts of the neck
Anticoagulant therapy	Surgery of the colon
Use of tobacco	Surgery of the rectum
Alcoholism	Rice diet
Catholic physicians	Treatment of acne
Gold toxicity	Eye diseases
Collagen disease	Glaucoma
Nutrition	Polyhydramnios
Rh factor	Public health
Cellulitis	Industrial injuries
Myanesis	Histamine therapy
Vitamins	Embryology
Private hospitals	Histology
History of medicine	Hearing aids
Rabies	Constipation
Rickets	Cancer in children
Diarrhea	Hodgkin's disease
Medical times	Rheumatoid arthritis
Pancoast tumors	Paravertebral block
Trench foot	Rh factor in abortion
Tests for intoxication	Papular urticaria
Steroid hormones	Life expectancy
Erythema multiforme	Immaturity
Pemphigus	Physical medicine
Treatment of empyema	Diabetes mellitus
Use of low sodium diet	Ophthalmology
Eosinophilia	Protein therapy
Subdural hematoma	Allergy
Syncope	Heart disease
Dyspnea	Bronchiectasis
Urinary tract	Intestinal obstruction
Atomic energy	
Disseminated lupus erythematosus	
Use of streptomycin in granuloma inguinale	
Dermatitis from dry cleaning fluids	
Pneumoconiosis of coal miners	
Convulsions in infants and children	
Periodic health examinations	
Mesenteric vascular occlusion	
Medicine and surgery in colonial times	
Medical education in the United States	

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Prepared by the Commission on Diabetes of The
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CASE V

Insulin Atrophy

(Reading time 50 seconds)

A female child, B. S., with a family history of diabetes mellitus present in the paternal grandfather, uncle, and great grandmother, was found to have glycosuria and hyperglycemia at the age of 6. In addition to dietary restriction of carbohydrate, the patient was started on 12 units of protamine and 10 units of crystalline insulin in separate injections. This régime controlled the patient's symptoms. She gained weight and increased in height at a normal rate. At the end of the first year of treatment, however, she was found on examination to have marked atrophy in the thighs and tumefaction in the upper arms at the sites of insulin injection (see photograph). The atrophy had appeared



despite careful rotation of the injection sites. This unexplained complication of insulin therapy occurs in about one-quarter of diabetic children. In adults it is present more often in women than in men.

CASE VI

Therapy for Mild Diabetic

(Reading time 60 seconds)

W. W., a white male, age 48, was first seen March 7, 1949. He had been told in 1926 that he had diabetes and was hospitalized at that time. He refused insulin and followed no diet until June, 1948, when he was started on a measured diet and insulin.

The essential physical findings were as follows: The

weight was 137 pounds, the blood pressure 145/80. "His vision was limited to hand movements in both eyes due to extensive retinitis proliferans with neovascularization in both fundi. The left had extensive vitreous hemorrhages, preventing all view of the details." (F. H. Adler) There was mild prostatic hypertrophy; pulsations were absent below the femorals in both lower extremities.

He is well controlled on a diet of protein 110 grams, fat 100 grams, carbohydrate 200 grams, and a mixture of 8 units of protamine zinc insulin and 18 units of regular insulin before breakfast.

His loss of vision has been progressive in spite of treatment with rutin and a high vitamin and high protein diet. This is an extreme case of a very common complication of diabetes. It suggests that most intensive therapy is necessary for the mild diabetic if complications are to be avoided.

In this patient it seems that the duration of the disease and the long period of poor control produced the vascular damage rather than the severity of the disease.

THE POCKETBOOK NERVE

"My truck-driver husband paid \$86 to his union last year, just for belonging. He says that some unions already are asking for more for their political campaign. How come the doctors can run their campaigns for an assessment of \$25?"

That question, posed in one of the many letters stimulated by the National Education Campaign of the AMA, sent a researcher to the telephone at the request of the Board of Trustees.

Here are fees reported paid just for membership, not for special activities, by members of typical organizations:

Teamsters Union local:	
Initiation fee	\$100.00
Annual dues	75.00
Architects	45.00
American National Retail Jewelers	150.00
Chicago Newspaper Guild, on earnings of \$100 per week	60.00
Insurance men, typical groups	50.00
Purchasing agents	35.00
Motion picture operators	42.00

—Pittsburgh Medical Bulletin.

ABUSED BODIES AND BRAINS

Most people have but little idea how to care for their bodies, or how to use their brains, or be well and happy. Millions of them keep themselves under the partial influence of caffeine, alcohol, nicotine, aspirin, and other drugs a good deal of the time. From childhood they never play fair with the finest machine on earth. The doctors themselves are not always good examples, and many of them care for their automobiles better than they do for themselves.—RAY LYMAN WILBUR, M.D.

SHIP'S SURGEONS
OF R. M. S.

Queen Elizabeth

REPORT:

"Dramamine has
caused almost com-
plete disappearance
of seasickness."



SUBSTANTIATING the findings of American investigators¹⁻³ on the effectiveness of Dramamine in the prevention and control of motion sickness, the ship's surgeons⁴ of the world's largest ship report their findings in a letter to the British Medical Journal:

"We have been reserving it (Dramamine) for the cases in which hyoscine has been of little or no benefit. We have found that in almost every case Dramamine has caused almost complete disappearance of seasickness . . . we find that 50 mg. twice daily will keep most people happy."

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Gay, L. N., and Carliner, P. E.: The Prevention and Treatment of Motion Sickness: I. Seasickness, *Bull. Johns Hopkins Hosp.* 84:170 (May) 1949.

2. Strickland, B. A., and Hahn, G. L.: The Effectiveness of Dramamine in the Prevention of Airsickness, *Science* 109:359 (April 8) 1949.

3. Lederer, L. G.; Kidera, G. J., and Tuttle, A. D.: Medical Aspects of Passenger Flight in Commercial Airlines, presented at the Aero Medical Association Convention, New York, N. Y., (Aug. 31) 1949.

4. Rust, S. M., and Fosbery, F. W. A.: Prevention of Seasickness (Correspondence), *Brit. M. J.* 2:98 (July 9) 1949.

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

COUGH is a common symptom, yet often it is not evaluated properly nor treated effectively. The physician is confronted with the questions: What is a cough? What are the causes of coughing? What should be done about it?

COUGH

Cough may be distressing and purposeless, but more often it is a necessary and useful act. Cough can be produced voluntarily, but more commonly it is a reflex response frequently reinforced by volition.

The act of coughing can be divided into three phases, namely, inspiratory, compressive, and expiratory. During the inspiratory phase there is a deep, often quick inspiration, followed by closure of the glottis. This results in an increase in intrapulmonary pressure, the compressive phase, immediately preceding expiration. During the expiratory phase the air is forced out with the production of characteristic cough sounds.

The function of cough is the removal of mucus, inflammatory exudate, and other material from the air passages, or foreign bodies and other materials which may have been aspirated into the tracheobronchial tree.

Cough is a complex act which depends for its effectiveness on a number of factors. Important among these are bronchial movements which are dependent upon the ability of bronchi to elongate and increase their diameter during inspiration and to shorten and decrease their diameter during expiration. During the expiratory phase there is also forcible compression of the lung through action of the diaphragm and the chest wall.

The narrowing of the bronchus is greatly accentuated in asthmatics and in cases of pulmonary emphysema. It is observed least in persons

with pulmonary fibrosis or anthracosilicosis. This compressive action forces secretions upward into the larger bronchi.

Ciliary function is important in the elimination of secretions from all portions of the airway except the terminal bronchioles. During acute infections with excessive or tenacious secretions, the activity of cilia may be greatly impaired.

The establishment of a condition of tolerance may lessen or obliterate temporarily the reflex cough. This is commonly observed in patients with bronchiectasis who are able to go without coughing for hours. When cough is initiated volitionally, they may evacuate several ounces of pus before again relapsing into a state of tolerance.

What are the causes of cough? In the common respiratory diseases such as pulmonary tuberculosis, pulmonary abscess, or other pulmonary diseases, cough is a frequent symptom, and the cause can be demonstrated by roentgen study and physical examination. Excessive smoking and chronic alcoholism produce local congestive changes in the pharynx, larynx, and tracheobronchial tree which give rise to cough. Exposure to dust and fumes exerts an unfavorable influence on the respiratory tract. An extra-respiratory cause of cough may be irritation of the external auditory canal, or nasal and pharyngeal obstruction. Cough may be associated with the taking of food or fluid, in paralysis of the larynx, or in laryngeal disease. Severe productive cough occurring when one changes posi-

tion suggests either pulmonary abscess, bronchiectasis, or empyema with bronchopleural fistula.

In investigating this symptom a careful history of the onset and character of the cough, the presence and appearance of sputum, the time of occurrence, and associated symptoms are important.

A study of the chest and the cardiovascular system should be made. The more common causes of cough should be excluded first. One should then proceed with an examination of the ears, nose, mouth, throat, laryngopharynx, larynx and neck, which can be done by any physician who has a reasonable knowledge of the upper air and food passages. The inveterate smoker should be encouraged to discontinue smoking and the worker in dust or fumes should minimize exposure in the absence of any definite localizing evidence of disease. Unexplained radiographic shadows or localized physical signs indicate bronchoscopy if the patient is an adult male. Cough with or without slight sputum is a common early symptom of bronchogenic carcinoma.

Bronchography is indicated if there is any suspicion of increased bronchopulmonary markings suggesting bronchiectasis. With a history of allergy, appropriate tests should be made.

The patient may be contented with the effects of a cough sedative or intralaryngeal instillations. The physician, however, should be interested in determining the cause of the cough.

Cough is necessary to rid the tracheobronchial tree of excessive secretions as in pulmonary abscess or bronchiectasis and in these narcotics should be used sparingly. In carcinoma, cough commonly is purposeless and is an early manifestation of bronchial irritation. In the postoperative case the cough "reflex" should not be suppressed. There must be adequate drainage of the tracheobronchial tree to prevent bronchial obstruction with secretions and postoperative pulmonary atelectasis.

If cough is purposeless, cough sedatives may be indicated. When cough is inadequate, so-called stimulating expectorants are recommended. Inhalations of carbon dioxide and oxygen increase the quantity of sputum, and have been highly recommended.

The physician must regard cough as a symptom and, although relief should be afforded the patient while the cause of cough is investigated, merely suppressing cough with a narcotic often will prove harmful.

Cough, Louis H. Clerf, M.D., The Mississippi Doctor, July, 1949.



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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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FOURTH ANNUAL CONFERENCE AND SCHOOL OF INSTRUCTION

The fourth annual conference and school of instruction for presidents and committee chairmen of county auxiliaries will be held in conjunction with the mid-year board meeting, March 9 and 10, in the Penn-Harris Hotel, Harrisburg.

The conference is especially planned to help counties to understand auxiliary work; to bring helpful suggestions to new presidents, officers, and committee chairmen; and to provide for an informal exchange of plans for programs and projects.

County presidents are asked to see that the incoming presidents for 1950-51 attend this conference. The program will be geared to give suggestions for setting up county programs ahead of time.

There will be six hours of instruction, suggestions, and ideas, designed to make auxiliary work more clearly understood, more enjoyable, and more effective.

Sessions start with dinner at 6 p.m., Thursday, March 9, and close with luncheon on Friday, March 10. Mrs. Howard H. Hamman will preside.

COUNTY PRESIDENTS 1949-50-51! This is *your* conference.

You will be teacher and pupil.

You will bring helpful ideas and suggestions for others.

You will see and hear how others do the job.

You will receive instructions in the fundamentals of auxiliary programs and projects.

You are urged to bring all interested auxiliary members to this conference, especially public relations and legislation chairmen.

Special classes for secretaries and treasurers will be held.

Demonstrations on conducting meetings, planning programs, study groups, and membership contacts will be given.

This is *your* conference—send any member interested in the Auxiliary, especially those who are to be future leaders.

Be sure that *you* as presidents for 1949-50 and 1950-51 attend.

Reservations for hotel rooms are made direct with the hotel.

Reservations for luncheon and dinner are made with Mrs. Charles W. Smith, 2303 Valley Road, Harrisburg, Pa., chairman of the committee on arrangements.

(MRS. DRURY) ELIZABETH M. HINTON,
President.

ERIE HEALTH EXHIBIT

An intriguing permanent exhibit of medical and health lore opened in November in Erie's Public Museum, under sponsorship of the Woman's Auxiliary to the Erie County Medical Society.

Set up in an attractively planned second-floor room of its own, the exhibit is displayed in a modernistic mode, with numerous wall panels, models, and other medical and health items carrying out the theme.

John Alexick, museum director, and his staff were responsible for designing and planning the room and also built the various exhibits.

One section is devoted to the history of medicine, with special emphasis on Erie's early medical history. Among the items displayed are the leather kit used by Dr. Usher Parsons, surgeon in Commodore Oliver Hazard Perry's fleet, and a collection of early medical instruments. Among these are an ornate barber-surgeon's bowl from Fifteenth Century Spain, an early stethoscope, an instrument used for opening abscesses, a scarificator, also blood-letting instruments and a turnkey used in the extraction of teeth. Most of these instruments were collected locally. Dr. Katherine Law Wright was the



HEALTH EXHIBIT The first permanent public health exhibit under the sponsorship of a county auxiliary was recently opened in Erie's Public Museum. Viewing the section of the exhibit portraying a healthy heart are the members of the Exhibit Committee of the Woman's Auxiliary to the Erie County Medical Society, *left to right*, Mrs. Usher H. Meyers, Mrs. Ernest L. Armstrong, Mrs. Irwin C. Krueger, and Mrs. James D. Stark.

donor of a glass retort used by Dr. Louis Pasteur, the famed bacteriologist, in his laboratory in France.

Another collection shows numerous items of apothecary equipment, including an early pill roller and a scales, from the collection of John Reinhold, local pharmacist. Still another portion of the collection shows the medical diploma and various lecture cards of Dr. Sanford Dickinson, early Erie physician.

COUNTY PRESIDENTS

Read in this issue about the Harrisburg conference to be held March 9 and 10.

The room also contains wall displays showing the function of the human heart, the digestive system, the circulatory system, the working of the eye, and the endocrine system. These are supplemented by charts and models showing various bodily organs and their functions. Another panel is devoted to tuberculosis and shows a model of the Erie County Tuberculosis Hospital and a model of the human chest. When a button is pressed, this is illuminated to show a typical chest x-ray plate.

While the basic exhibit is permanent in nature, changes and additions will be made from time to time to keep abreast of trends in medicine.

Members of the auxiliary committee assisting in preparing the exhibit visited similar exhibits

in Cleveland to secure ideas for the local display.

The Erie Auxiliary, through its new health exhibit undertaking, hopes to bring to the public an opportunity for better understanding and appreciation of the medical arts and sciences and civic health.

(MRS. ERNEST L.) MARGARET L. ARMSTRONG,
Publicity Chairman, Erie County.

WHEELS TURNING

Our president has been very busy touring the State on her visits to counties, setting in motion the wheels of auxiliary progress, adjusting the load of duties and responsibilities, and clocking each county's pace toward definite goals. These visits will be reported in the February PENNSYLVANIA MEDICAL JOURNAL. Everywhere following her coming there has been renewed interest and greater determination to keep the wheels turning for Auxiliary progress.

BEAVER county's opening meeting of the current season was held September 20 at Sheffield Towers, New Sheffield, with the Aliquippa group as hostesses at luncheon. One new member, Mrs. John D. Gaydos, was introduced. Delegates and alternates were appointed to attend the convention at Pittsburgh. Bridge followed the business session.

CLINTON county members were entertained at an afternoon tea with their president, Mrs. William C. Long, hostess at the first fall session. Committee chairmen appointments were announced. Mrs. Frank P. Dwyer and Mrs. David W. Thomas reported on the Pittsburgh convention. Both women had been honored at the state meeting, Mrs. Thomas having presided at a luncheon, and Mrs. Dwyer given honorary membership in recognition of her efficient work as secretary of the Pennsylvania Auxiliary for the last fifteen years.

DELAWARE county met on October 13 to hear Mr. Gar Young, eastern representative of the Public Relations Committee of the State Medical Society. This county is holding a series of bridge parties for the benefit of the Medical Benevolence Fund.

On September 12 ERIE county voted to donate two hundred dollars to Lake View Hospital toward the purchase of an iron lung or other vital equipment needed in the treatment of polio cases. The guest speaker was Mr. Keith R. Hutchison of the Public Relations Committee of the State Medical Society.

ERIE also had a successful card party and style show in the fall to raise funds for the purchase of material for their health exhibit, of which they are justly proud. They invite other auxiliaries to visit the exhibit as an incentive to the organization of similar projects in other counties.

At the October 6 meeting of FAYETTE county, a covered dish supper was served in the Woman's Hospital Association rooms; routine business was conducted, and yearbooks were distributed, the covers of

which are silver in honor of their twenty-fifth anniversary. The proceeds of a dance held November 18 will go to the Medical Benevolence Fund.

During the November 3 meeting of FAYETTE, at the Annette Nurses Home, a motion was made that a scholarship in memory of Mrs. Paul Staman be given to some worthy student chosen by a committee with Mrs. Holbert J. Nixon as chairman.

A tea followed the meeting in honor of their twenty-fifth anniversary and to welcome new members. William A. McHugh, M.D., discussed "Socialized Medicine."

At the LACKAWANNA county luncheon meeting, November 8, at the Scranton Club, Michael G. O'Brien, M.D., president of the medical society, and Milton J. Goldstein, M.D., president-elect and advisor to the auxiliary, spoke to the group.

Counties may wish to duplicate LEHIGH county's program of September 13. Mrs. Donald W. Haff, program chairman and study group instructor, introduced auxiliary members who spoke on the aims, origin, and accomplishments of the auxiliary, bringing the real meaning of the group's work to the fore. Mrs. William J. Hertz traced the history of the group, organized in

1919, and stated that it was the first medical auxiliary in the state of Pennsylvania and the oldest in the United States. Medical benevolence, one of the principal auxiliary functions, was described by Mrs. J. Frederic Dreyer; and Mrs. Julius Friedman spoke of the Nurses' Scholarship Fund, one of the local projects. Mrs. John J. Schneller, legislative chairman, talked on compulsory health insurance and urged members to carry on with their personal contact campaign. She said that the American Medical Association's 12-point program expresses the opinions, beliefs, and programs of the member societies for the advancement of medicine and public health. Tea was served following the program.

At the October meeting of LEHIGH, highlights of the state convention were presented. The auxiliary contributed \$150 to the Community Chest. Mrs. T. H. Hazlehurst, of Bethlehem, an authority on fine table wares, both old and new, spoke to the group on period table settings. She had tables set in various patterns of china, silver, crystalware, and linens of different periods, some modern and some old. A tea followed the program.

NORTHAMPTON county met at the Hotel Bethlehem on September 13 to get acquainted with new



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members and to go on record, through the adoption of resolutions, as opposing compulsory health insurance. Delegates to the state convention were appointed and yearbooks distributed to members.

On October 12, at a luncheon meeting in the Hotel Easton, NORTHAMPTON's plans for their second annual health poster contest were announced. Mrs. Paul W. Schuessler, Easton, is serving as chairman, working with Thomas H. A. Stites, M.D., Nazareth, who is director of the contest in the county for the medical society. A committee of twelve women was appointed to serve with Mrs. Schuessler. Miss Mary H. Stites, councilor, gave a report on the convention held in Pittsburgh. A question and answer program on *Hygeia* was presented with Mrs. Melvin M. Berger, Bethlehem, and Mrs. Charles A. Waltman, Easton, serving as quiz masters.

Yes, we are on the move. Wheels turning steadily and surely spell progress in the year's program.

Summarized by

(MRS. RUFUS M.) CLARA R. BIERLY,
1947-48 State President.

1949 CONFERENCE OF WOMAN'S AUXILIARY TO AMA

On November 3 and 4 the wives of one hundred physicians, representing 43 state auxiliaries—state presidents and presidents-elect and national officers and chairmen of standing committees—attended the sixth annual Conference of the Woman's Auxiliary to the American Medical Association held in the Illinois Room of the Hotel LaSalle, Chicago, Ill. There are 49,574 members from 48 states and Hawaii who belong to the Woman's Auxiliary to the American Medical Association, whose purpose is the promotion of friendship, fellowship, and service.

The conference theme was "The AMA 12-Point Program." Mrs. David B. Allman, Atlantic City, N. J., national auxiliary president, in keynoting the conference, announced that its purpose was to consider the role of the Woman's Auxiliary in promoting the American Medical Association's 12-point program, which has been designed to improve the health of the nation and which advocates:

1. Creation of a Federal Department of Health with a secretary of cabinet status who is a doctor of medicine.
2. A National Science Foundation for the promotion of medical research, with grants to qualified institutions.
3. Further development of and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with rapid extension into rural areas.
4. A medical care authority in each state, for proper representation of medical and consumer interests.
5. Encouragement of new diagnostic facilities, health centers, and hospital services, locally originated, administered, and controlled, in rural and other areas, as provided by the National Hospital Survey and Construction Act.

6. Establishment and improvement of local public health units, services, and centers.

7. A national mental hygiene program, with aid to clinics.

8. Expanded health education programs to inform citizens of the available facilities and their own responsibilities.

9. Facilities for the care and rehabilitation of the aged and those suffering from chronic disease.

10. Maintenance of existing high standards of medical care for veterans, plus extension of facilities.

11. Greater industrial medicine program; safeguards against industry hazards and highway and home accidents.

12. Adequate funds for medical, dental, and nursing schools, and other medical training institutions.

During the opening session Mrs. Allman issued the Call to Order, extended the welcome to the conference, and presented the president-elect, Mrs. Arthur A. Herold, chairman of the conference.

The guest speakers on Thursday's program were Andrew C. Ivy, M.D., vice-president of the University of Illinois Professional Schools, who spoke on "Medical Education and Research"; Fred V. Hein, Ph.D., AMA consultant in health and fitness and a member of the AMA Speakers' Bureau, who explained the "School Health Program"; and Mr. Lawrence Rember, AMA public relations director, who defined and stressed "Public Relations."

In his speech on medical education and research, Dr.

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Ivy said: "The prime interest of the physician is the taking care of the welfare of the sick patient"; also, "85 per cent of medical research is going on through grants. See that money sent to Washington is spent right, and that it is not wasted nor stolen." In regard to the school health program, Dr. Hein stated that there should be joint planning in health education, and he urged that the medical profession participate in school health councils, and that appointments of representatives on these councils be approved by the state medical societies. He also urged that the state medical societies sponsor rural health programs and that articles concerning good health programs be sent to state headquarters from areas conducting such programs, so that they may be distributed and used elsewhere to good advantage. Concerning public relations, Mr. Rember discussed the way in which the AMA 12-point program should be promoted; he emphasized the need for better facilities to attract physicians to the rural areas, and he stressed the urgent need for support of the National Education Campaign.

During the luncheon session, Mrs. Charles W. Sewell, who is the administrative director of the Associated Women of the American Farm Bureau Federation, gave a vital and interesting address on "The Farm Bureau Federation and the Health Problem," in which she compared present-day animal husbandry with standards for human beings. Mrs. Sewell emphasized the need for close cooperation between the Auxiliary and the Farm Bureau.

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The conference program on Friday consisted of recommendations from committee chairmen; a discussion of auxiliary activities by state presidents and presidents-elect; and a résumé of conference proceedings given by the national president-elect, Mrs. Herold. Some of the highlights from the recommendations of committee chairmen follow: Mrs. Paul C. Craig, national public relations chairman and past president of the Pennsylvania Auxiliary, emphasized the need for assistance in promoting point 2 in the AMA's constructive and progressive program, namely, "A National Science Foundation for the promotion of medical research, with grants to qualified institutions." Mrs. Craig also urged that the auxiliary members become better prepared through instruction provided by panel discussions and study groups, so that they may be better able to speak before various groups and inform the public with clarity and confidence. She advised that study groups be open to all interested lay people as well as to auxiliary members. She suggested that all auxiliaries work untiringly to have church groups, women's clubs, P.T.A.'s, service and patriotic organizations, etc., sponsor resolutions favoring voluntary health insurance and opposing socialized medicine; that they cooperate with state departments of health and lay organizations in Health Day programs; and that every auxiliary member become familiar with and be guided by the 12-point program, whose primary aim is to improve health conditions, and in which may be found sufficient material for one solid year of program planning and speech making. A lively and enlightening question and answer period followed the presentation of Mrs. Craig's recommendations.

Mrs. Harold F. Wahlquist, organization chairman, said: "Organization means unification." Mrs. Herbert W. Johnson, *Hygeia* chairman, explained that the need for an authentic health magazine was felt in 1922; that in 1931 the Woman's Auxiliary was asked to help promote the sale of *Hygeia*, and that 20,000 units were sold in 1948. Mrs. Bruce Shaefer, legislation chairman, urged that each auxiliary devote some space in its correspondence in which to instruct and advise members, as constituents, when and where to write to their Congressmen and United States Senators, requesting a reply stating their stand and opinions on legislation, and always remembering in every instance to write and thank these representatives for information given.

The guest speakers on Friday were James R. Miller, M.D., chairman of the Commission on Chronic Illness, and a member of the Board of Trustees of the AMA, who spoke on the function and activities of the Commission on Chronic Illness; and Mr. Thomas A. Hendricks, secretary of the AMA Council on Medical Service, whose subject was "The Dead Horse and Community Health Leadership." Dr. Miller emphasized the work being done by the AMA and the hospital groups. Mr. Hendricks referred to the program of the White House Children's Conference, and he advised that auxiliaries should assume leadership in promoting health programs in their communities.

The luncheon speakers on Friday were officers of the AMA: Ernest E. Irons, M.D., president; Elmer L. Henderson, M.D., president-elect; J. L. Moore, M.D., treasurer; and George F. Lull, M.D., secretary and

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GYNECOLOGY—Intensive Course, two weeks, starting February 20. Vaginal Approach to Pelvic Surgery, one week, starting March 6.

OBSTETRICS—Intensive Course, two weeks, starting March 6.

PEDIATRICS—Intensive Course, two weeks, starting April 3. Personal Course in Cerebral Palsy, two weeks, starting July 31.

MEDICINE—Intensive General Course, two weeks, starting April 24. Hematology, one week, starting May 8. Gastro-enterology, two weeks, starting May 15. Liver and Biliary Diseases, one week, starting June 5. Gastroscopy, two weeks, starting March 6.

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general manager. The members of the executive committee of the Board of Trustees of the American Medical Association were guests of honor at this luncheon. Louis Bauer, M.D., a member of the Board of Trustees, warned that money accepted from the government for medical schools would simply supply the government with a wedge enabling it to gain complete control.

In conclusion, we as doctors' wives were constantly impressed with the fact that we all have responsibilities toward our communities. We were urged to insist that local medical facilities be made adequate; that people in rural areas encourage young doctors to establish practices there; and we were advised that the books, *The Road Ahead* by John T. Flynn and *Power in the People* by Felix Morley, should be "must" reading for all doctors and their wives.

(MRS. HOWARD H.) MARY STEEL HAMMAN,
President-elect.

MAKING HEALTH VISIBLE

The Medical Society of the State of Pennsylvania maintains a library of 16 mm. sound films on health subjects suitable for lay audiences which are available, on loan, to county medical societies, individual physicians, hospitals, service and women's clubs, schools, and other groups. There is no charge for these films other than the cost of return postage and insurance. Requests for films should be addressed to the Committee on Public Relations, The Medical Society of the



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A Criminal Is Born (MGM)

Lincoln School Parent-Teacher Association, Harrisburg
Adult Education Group, Muncy

Accent on Use (National Foundation for Infantile Paralysis)

Foose Parent-Teacher Association, Harrisburg

Be Your Age (Metropolitan Life Insurance Company)

Nurses and lay personnel of Cresson Sanatorium
Cosmopolitan Club of Harrisburg

Boy in Court (National Probation Association)

Woman's Fire Company Auxiliary, Blain

Cancer: The Problem of Early Diagnosis (American Cancer Society)

Veterans Administration, Aspinwall
Indiana County Medical Society

Choose to Live (American Cancer Society)

Woman's Democratic Club, Clearfield

Eyes for Tomorrow (National Society for the Prevention of Blindness)

Auxiliary to the Pennsylvania Association for the Blind, Harrisburg

Feeling of Rejection (National Film Board)

Mothers' Club, Our Mother of Sorrows School, Johnstown
Harrisburg State Hospital staff
Young adult group, Jewish Community Center, Harrisburg
Allison School Parent-Teacher Association, Harrisburg

First Aid (MGM)

Dalton Public Schools
Miss Margaret Loh, R.N., Altoona Hospital

Human Heart (March of Time)

Nurses and lay personnel of Cresson Sanatorium
Medical staff, Veterans Administration Regional Office, Pittsburgh

Human Growth (University of Oregon)

Dalton High School
Downey School Parent-Teacher Association, Harrisburg
Tatamy Parent-Teacher Association

Life with Baby (March of Time)

Mrs. James C. Schornick, Clearfield

Miracle Money (American Cancer Society)

Methodist Church, Perryopolis
Elementary School, Star Junction

Modern Guide to Health (Young America Films)

Mothers' Club, Our Mother of Sorrows School, Johnstown
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**Reprints on Request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngo-
scope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp.
Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol.
35, 6-1-25, No. 11, 590-592.

MEDICAL NEWS

Birth

TO DR. AND MRS. MORTON McMICHAEL, of Wayne, a daughter, Lucy McMichael, December 9.

Engagements

MISS SHIRLEY NORMA RAU, of Penn Wynne, to Mr. L. Roy Wilson, son of Dr. and Mrs. Lucius R. Wilson, of Wynnewood.

MISS EMILY DOROTHY BOYLE, daughter of Dr. and Mrs. Joseph P. Boyle, to Mr. Charles Francis Sutton, all of Philadelphia.

MISS EDITH CARRUTH DAVIS, daughter of Dr. and Mrs. David M. Davis, of Haverford, to Mr. Laurens Lincoln Battis, of Boston.

MISS CAROLINE COX, of Princeton, N. J., to Mr. Lewis Cass Scheffey, Jr., son of Dr. and Mrs. Lewis C. Scheffey, of Merion.

MISS DOLORES LOUISE HORINE, daughter of Dr. and Mrs. D. Grove Horine, of Penn Wynne, to Mr. James E. Buck, Jr., of Philadelphia.

MISS ALONDA JUNE MILLER, daughter of Dr. and Mrs. C. Kenneth Miller, of Philadelphia, to Mr. Robert M. Savage, of Havertown.

MISS JULIA WESTKOTT SCHEFFEY, daughter of Dr. and Mrs. Lewis C. Scheffey, of Merion, to Mr. Harvey M. Buckman, of George School.

MISS AGNES HUTCHINSON STROUD, daughter of Dr. and Mrs. William B. Stroud, of Villanova, to Mr. Harold A. Ball, Jr., of Philadelphia.

MISS CHARLENE WILKENS, of Forest Hills, N. Y., to Mr. Robert Devers Hursh, son of Dr. and Mrs. Alexander M. W. Hursh, of Philadelphia.

MISS RUTH FRANCES McKINNEY, daughter of Dr. and Mrs. Walter B. McKinney, of Broadaxe, to Mr. William Balderston, 3d, of Meadowbrook.

MISS MARY ANN HARRISON FITZ-HUGH, daughter of Dr. and Mrs. Thomas Fitz-Hugh, Jr., of Wynnewood, to Mr. Dean Tolle Mace, of New York.

MISS DOROTHEA MILLER MANNING, of Norwood, to Charles Keally Liddell, M.D., of Pittsburgh. Dr. Liddell is stationed at the hospital of the U. S. Military Academy, West Point.

Marriages

MISS FRANCES MAE RITTENBERG, daughter of Dr. and Mrs. Benjamin B. Rittenberg, to Mr. Richard Fish, all of Philadelphia, December 18.

MISS GLORIA EADE GALLIC, of Windsor, Conn., to Mr. Philip Powers Perkins, son of Dr. and Mrs. J. Ashbridge Perkins, of Coatesville, December 23.

MISS MARY JANE MILLER, daughter of Dr. and Mrs. Hugh McCauley Miller, of Wyncote, to Mr. Herinan Frederick Scheurer, Jr., of Baederwood, December 17.

MRS. M. KLEVAN CANBY, daughter of Dr. and Mrs. Oscar J. Klevan, of West Chester, to Mr. Lisle Smith, of Sandford Barbados, British West Indies, December 17.

MISS MARY ALICE GRABE, of Camp Hill, to David Dale Kirkpatrick, Jr., M.D., of Saegerstown, December 29. Dr. Kirkpatrick is on duty with the Navy at the Philadelphia Naval Hospital.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ A. Parker Hitchens, Philadelphia; Medico-Chirurgical College of Philadelphia, 1898; aged 72; died Dec. 10, 1949, after a long illness. A retired lieutenant colonel of the Army Medical Corps, Dr. Hitchens until recently had been director of the Bureau of Laboratories of the Pennsylvania Department of Health. Early in his career he was director of the Mulford Biological Laboratories for 12 years. In 1920 he began research work in the U. S. Public Health Service and became an assistant professor in the Army Medical School. He had held important posts in the school and in Walter Reed Hospital. From 1925 to 1929, he had extensive experience in the public health administration of the Philippine Islands, where he served on Gen. Leonard Wood's staff as technical adviser in public health and sanitation. He was also president of the Philippine Leprosy Research Board, and organized the School of Public Health and Preventive Medicine as part of the University of the Philippines. In 1939 Dr. Hitchens was appointed George S. Pepper professor of public health and preventive medicine at the University of Pennsylvania, the first such department at the university's medical school. From 1944 to 1947, Dr. Hitchens served as City Health Commissioner for Wilmington, Del. He was a member of the Philadelphia Department of Public Health in 1940 and for a time was chief of medical emergency services of the Philadelphia Council of Defense. He had served as president and secretary of the American Association of Pathologists and Bacteriologists, and was a Fellow of the American College of Surgeons and of the American Public Health Association. Surviving are his widow, a son, and a daughter.

○ Abraham J. Cohen, Philadelphia; Jefferson Medical College of Philadelphia, 1903; aged 70; died Dec. 30, 1949, from a heart condition. Dr. Cohen was clinical professor of medicine in the diseases of the chest at Temple University Medical School since 1921, and was director of the Division of Tuberculosis of the City Department of Public Health from 1928 to 1931. He had served as medical director of Eagleville Sanatorium since its inception in 1909. He was a consultant at Jewish Hospital and Norristown State Hospital. Dr.

Cohen was visiting physician at White Haven Sanatorium from 1907 until 1911, and was physician to the tuberculosis division at Philadelphia General Hospital from 1924 to 1928. He was associated with the Henry Phipps Institute from 1905 to 1927, serving for seven years as associate director of the clinical and sociologic work of that institution. He was a member of the American Trudeau Society of the National Tuberculosis Association and the American College of Chest Physicians, for which body he was currently vice-chairman of a commission on a special research program connected with advanced tuberculosis treatment. Surviving are his widow, a son, Robert V. Cohen, M.D., who was associated with him, three brothers, one of whom is Louis Cohen, M.D., of Philadelphia, and three sisters.

○ **Augustus A. Eshner**, Philadelphia; Jefferson Medical College of Philadelphia, 1888; aged 87; died Dec. 20, 1949. Until he suffered a stroke last September, he had been in active practice for more than 60 years. He was formerly chief clinical assistant in the outpatient department of Jefferson Medical College Hospital and was professor of clinical medicine from 1895 to 1918 at the old Philadelphia Polyclinic Hospital. Dr. Eshner was affiliated at various times with the Orthopedic Hospital and Infirmary for Nervous Diseases, the Hospital for Diseases of the Lungs, and Mercy Hospital. During World War I, he served as a first lieutenant in the Army Medical Corps Reserve. He was the author of many medical monographs and articles, and translator and editor of many others. At one time he served as an associate editor of the *PENNSYLVANIA MEDICAL JOURNAL*. He was co-author of *Essentials of Medical Diagnosis*, published in 1892, and the author of *Handbook of Fevers*, published in 1895. He took an active interest in civic affairs and public issues and frequently wrote to newspaper editors setting forth his views on numerous subjects. He was also a member of many organizations. Dr. Eshner is survived by his widow and two daughters, one of whom, Dr. Juliet E. Nathanson, is also a physician.

○ **Henry D. Jump**, Philadelphia; University of Pennsylvania School of Medicine, 1893; aged 82; died Nov. 17, 1949. Dr. Jump was at one time professor of applied therapeutics at Woman's Medical College of Pennsylvania and consulting physician at the Philadelphia General and Misericordia Hospitals. In his medical career he took special postgraduate work in Berlin and Dresden. During World War I, he served in the Medical Corps of the Army with the rank of major and subsequently resigned from the Army Medical Corps Reserve with the rank of lieutenant colonel. He served as president of The Medical Society of the State of Pennsylvania in 1920 and in a similar capacity for the Philadelphia County Medical Society in 1917. He also served on the board of censors of his county medical society for many years. He specialized in internal medicine and during the later years of his active practice was regarded as an excellent medical consultant. He is survived by his widow.

○ **Samuel R. Haythorn**, Pittsburgh; University of Michigan Medical School, Ann Arbor, 1904; aged 69;

died Dec. 6, 1949. An outstanding pathologist, Dr. Haythorn was renowned for his research work in tuberculosis, silicosis, and cancer. He was director of the William H. Singer Memorial Research Laboratory of Allegheny General Hospital, which institution he had helped to develop. For a number of years he was professor and head of the department of pathology and bacteriology at the University of Pittsburgh School of Medicine. He was a past president of the American Association of Pathologists and Bacteriologists and a member of its council, a past president of the American Society for Experimental Pathology, the International Association of Medical Museums, the Pittsburgh Academy of Medicine, and of the Allegheny County Medical Society. He was a Fellow of the American College of Physicians. One daughter and three grandchildren survive.

○ **Florence E. Kraker**, Media; Woman's Medical College of Pennsylvania, 1905; aged 72; died Jan. 3, 1950. After teaching obstetrics and gynecology at Woman's Medical College for a time and maintaining a private practice, she went to Shanghai, China, in 1922, where she taught for a year in the Margaret Williamson Hospital. She later was director of the division of maternal and infant hygiene in the Children's Bureau in Washington, D. C. Dr. Kraker formerly was a physician at the Delaware County Home. Since 1931 she had been a physician at the Cleighton Farms School for Girls. She is survived by two sisters and a brother.

○ **Harry A. Lakin**, Harrisburg; University of Maryland School of Medicine, Baltimore, 1903; aged 73; died Dec. 8, 1949. From 1910 to 1919, and from 1945 until his retirement in 1947, Dr. Lakin was assistant medical examiner for the Pennsylvania Railroad. He served 25 years as medical examiner for the Metropolitan Life Insurance Company, and was former chief anesthetist at Polyclinic Hospital for 20 years. He was a member of the American Society of Anesthetists, Inc. He is survived by his widow, a daughter, and a sister.

Roscoe C. Magill, New Hope; Medico-Chirurgical College of Philadelphia, 1906; aged 68; died Jan. 4, 1950. Dr. Magill was an eye specialist. He served for 24 years on the staff of Northeastern Hospital, and for 18 years on the staff of Lankenau Hospital, both in Philadelphia. He was a former Burgess of New Hope, and until he resigned nine years ago was superintendent of Washington Crossing State Park. He resigned from the Bucks County Medical Society early in 1949.

○ **Hiram C. Scott**, Waynesburg; Jefferson Medical College of Philadelphia, 1903; aged 74; died Dec. 13, 1949, following a brief illness. He was on the staff of the present Greene County Memorial Hospital, of which he was one of the organizers. Dr. Scott was a veteran of the Spanish-American War, and in later years was regimental surgeon of the "Fighting Tenth" Regiment of the Pennsylvania National Guard. He is survived by his widow, two daughters, and two brothers.

○ **Edwin A. Heller**, Philadelphia; University of Pennsylvania School of Medicine, 1895; aged 77; died Dec. 24, 1949, after a short illness. For many years

Dr. Heller served as medical chief at Jewish Hospital, and he was also on the staff of Stetson Hospital. In 1946 he was honored by the medical society for having completed 50 years of active practice. Two daughters survive.

○ **Austin C. Lynn**, Philipsburg; Medico-Chirurgical College of Philadelphia, 1911; aged 62; died suddenly from a heart attack Dec. 27, 1949. Dr. Lynn was chief of staff at the Philipsburg State Hospital and was active in civic affairs. He was a Fellow of the American College of Surgeons. Surviving are his widow, one son, two daughters, three brothers, and two sisters.

○ **Julius L. Werner**, Philadelphia; Jefferson Medical College of Philadelphia, 1905; aged 69; died Dec. 11, 1949. Born in Russia, Dr. Werner came to the United States as a child. He was chief of proctology at Mt. Sinai Hospital and was also on the staff of Graduate Hospital. He was a member of the American Proctologic Society. His widow and a sister survive.

○ **Edmund C. Boots**, Pittsburgh; University of Pittsburgh School of Medicine, 1920; aged 55; died Dec. 24, 1949. Dr. Boots was on the staff of the Columbia and the Tuberculosis League Hospitals and the consulting staff of the Woodville State Hospital. He was a member of the American College of Chest Physicians and a Fellow of the American College of Physicians.

○ **Richard H. Gollings**, Pittsburgh; Hahnemann Medical College and Hospital of Philadelphia, 1936; aged 43; died suddenly Dec. 11, 1949. During World War II, Dr. Gollings served as a flight surgeon with the Air Force, holding the rank of captain. He is survived by his widow, a son, his mother, a sister, and a brother.

○ **Daniel J. Donnelly**, Philadelphia; Temple University School of Medicine, 1906; aged 74; died Dec. 20, 1949, after a long illness. Dr. Donnelly had been assistant professor of medicine at Temple since shortly after World War I. He served during the war as a lieutenant colonel. Two daughters survive.

○ **George M. Dorrance**, Philadelphia; University of Pennsylvania School of Medicine, 1900; aged 72; died Nov. 21, 1949. Dr. Dorrance was certified by the American Boards of Surgery and Plastic Surgery. He was a Fellow of the American College of Surgeons and a member of the American Radium Society.

Marie Riegger, Philadelphia; Woman's Medical College of Pennsylvania, 1901; aged 76; died March 22, 1949. She left a \$167,954 estate. After specific bequests totaling \$90,100, the residue is to be awarded equally to the Salvation Army and the Friends Service Committee for Foreign Relief.

○ **Joseph A. Fitzmaurice**, Bala-Cynwyd; Columbia University College of Physicians and Surgeons, New York, 1926; aged 51; died Dec. 31, 1949, after an illness of several months. Dr. Fitzmaurice had offices in Philadelphia for many years. He is survived by his widow, a son, and two daughters.

Ella M. Russell, Chambersburg; Woman's Medical College of Pennsylvania, 1906; aged 71; died Dec. 5,

1949. She retired from practice in 1929. A brother and two nieces survive.

Richard R. Gates, Drexel Hill; Hahnemann Medical College and Hospital of Philadelphia, 1924; aged 48; died Dec. 13, 1949. His widow and a daughter survive.

George Hunter, Blairsville; Hahnemann Medical College and Hospital of Philadelphia, 1886; aged 86; died Dec. 19, 1949. A sister survives.

○ **John B. Sherbon**, Pottstown; State University of Iowa College of Medicine, Iowa City, 1904; aged 73; died Dec. 14, 1949.

○ **O. Luther Latchford**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1903; aged 75; died Dec. 17, 1949.

○ **James D. McClure**, Wilkinsburg; University of Pittsburgh School of Medicine, 1892; aged 84; died Nov. 30, 1949.

Miscellaneous

THE RECIPIENTS OF FIVE FELLOWSHIPS AWARDED ANNUALLY BY THE PHILADELPHIA DIVISION OF THE AMERICAN CANCER SOCIETY were announced recently. The fellowships have a cash value of \$2,400 each and are given to enable qualified young physicians to continue their study of the latest techniques in cancer diagnosis and treatment. The 1950 recipients and their hospitals are Drs. Morris Ivker (Jefferson), Leo B. Snow (Temple University), Mary Helen Cameron (Woman's Medical College), Charles Owen (Philadelphia

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General), and John M. Phillips (University of Pennsylvania).

THE INTERNATIONAL SOCIETY OF HEMATOLOGY will hold its Biennial Congress at the University of Cambridge, Cambridge, England, from August 21 through 26, 1950. The program committee is in the process of receiving titles for papers and scientific exhibits to be presented at the congress. Material to be submitted for consideration for the program may be sent to Israel Davidsohn, M.D., Mt. Sinai Hospital, Chicago, Ill., or Stacy R. Mettler, M.D., University of California, San Francisco, Calif. Those desiring to present scientific exhibits should make application as soon as possible.

THE CHILDREN'S HOSPITAL OF PHILADELPHIA has been given a March of Dimes grant of \$10,605 to enable scientists at the hospital to complete a study of nutrition in relation to resistance to poliomyelitis. Initiated in 1942, this study, which is a research project at the hospital, the Veterinary School and Department of Pediatrics of the University of Pennsylvania, continues to assay the effects of dietary alterations on re-

sistance or susceptibility of mice to polio virus. The work at the hospital is under the direction of T. F. McNair Scott, M.D., director of research at Children's Hospital.

THE FIRST INTERNATIONAL CONGRESS ON DISEASES OF THE CHEST will be held at the Carlo Forlanini Institute, Rome, Italy, Sept. 17 to 20, 1950, under the auspices of the Council on International Affairs of the American College of Chest Physicians and the Carlo Forlanini Institute, with the patronage of the High Commissioner of Hygiene and Health, Italy, in collaboration with the National Institute of Health and the Italian Federation Against Tuberculosis. Physicians who are interested in attending the congress should communicate at once with Chevalier L. Jackson, M.D., chairman of the Council on International Affairs, American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Ill., or with Professor A. Omodei Zorini, Carlo Forlanini Institute, Rome, Italy.

THE TENTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH will be held at the Roosevelt Hotel in New York City on Monday and Tuesday, Feb. 20 and 21, 1950. On this occasion the Council on Industrial Health of the American Medical Association welcomes the Medical Society of the State of New York as co-sponsor.

On Monday afternoon a panel of well-qualified experts in this field will discuss the variations in four major types of plans: (1) union plans, (2) management plans, (3) private insurance plans, and (4) medical society and Blue Cross plans.

Tuesday morning will be given over to a discussion of essential relations between the medical, engineering, and social sciences as they jointly relate to problems of production and human relations in industry.

Symposiums on Tuesday afternoon will deal with the experience of a large corporation in the development of new techniques for the selection, placement, and follow-up of employees, also the essential elements of case-finding programs in industry, and will demonstrate how early diagnosis can be improved and extended, particularly to the advantage of the small plant in the small community.

A TWO-DAY SECTIONAL MEETING OF THE AMERICAN COLLEGE OF SURGEONS is to be held at the Hotel William Penn, Pittsburgh, on March 14 and 15. This meeting will consist of all-day and evening conferences on timely surgical subjects and separate meetings for hospital personnel where hospital problems will be considered at panels and round table discussions.

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Members of The Medical Society of the State of Pennsylvania and the personnel of Pennsylvania hospitals are invited to attend this meeting. The Fellows of the College in Pittsburgh wish to assure all visitors that adequate hotel accommodations will be available and that they will be most welcome at all of the sessions.

J. Huber Wagner, M.D., of Pittsburgh, is chairman of the Committee on Arrangements.

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Physician Wanted.—To rent fully equipped offices of young physician recently deceased. Fine location. Write J. BOYD LANDIS, 8 W. High St., Carlisle, Pa.

For Sale.—Long-established eye, ear, nose, and throat practice. Contact FRED C. STAHLMAN, M.D., Charleroi, Pa.

Wanted.—Physicians under 40 years. Insurance examining. Reply giving personal data. PHILADELPHIA-UNITED LIFE INSURANCE COMPANY, Girard and Ridge Avenues, Philadelphia 30, Pa.

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Wanted.—Ophthalmologist or eye, ear, nose, and throat specialist to take over practice with office and equipment in thriving city, eastern Pennsylvania. Write MRS. R. C. MAGILL, New Hope, Pa.

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Anesthesiology Residency Available.—Approved by American Board. Open to graduates of approved medical schools with one-year internship. Apply DIRECTOR of ANESTHESIA, Mt. Sinai Hospital, Philadelphia 47, Pa.

For Sale.—1000 genuine engraved rag content letterheads, \$9.00, 120 styles lettering. 1000 thermographed featherweight appointment and business cards, \$4.00, 18 styles. Personal stationery. Samples gratis. ART LETTERHEAD, 210 Fifth Avenue, New York, N. Y.

Wanted.—Physician to take over practice in York County. Growing residential borough with population of 2000; area includes 7500. House and office available at once. Will help finance. Write YORK TRUST COMPANY, York, Pa.

Situation Wanted.—Young physician interested in becoming assistant to older practitioner, internal medicine or general practice, has special training in laboratory medicine. Pennsylvania license. Write Dept. 179, PENNSYLVANIA MEDICAL JOURNAL.

Assistant Wanted.—General practitioner and roentgenologist needs an assistant due to ill health. Office and location established over fifty years. Ear, nose and throat man preferred. Excellent X-ray equipment available. Write Dept. 175, PENNSYLVANIA MEDICAL JOURNAL.

Physicians Wanted.—Two general residents, 230-bed general hospital. Salary \$300, full maintenance. Must be graduates of approved medical school. Pennsylvania license or eligible for same. Appointments to be made immediately. Apply WESTMORELAND HOSPITAL, Greensburg, Pa.

For Sale.—Modern office and home with active established general practice. Added income from industrial, insurance, and railroad contacts. Location—large industrial community, one-half hour from downtown Pittsburgh. Leaving to specialize. Write Dept. 176, PENNSYLVANIA MEDICAL JOURNAL.

Residents Wanted.—Surgical and medical residencies in 135-bed general hospital, 12 months ending June 30, 1951. Not approved for training, but wealth of experience. Salary \$300 a month and maintenance. Pennsylvania registration required. Write LEWISTOWN HOSPITAL, Lewistown, Pa.

Medical Literary Research Bureau. Information, abstracts, bibliographies from old and current medical literature. Translations and photostatic copies provided. Ample reference facilities. REYNOLDS HAYDEN, M.D., Director, (Capt., Med. Corps, U.S.N., Ret.) 5411 Potomac Ave., N.W., Washington 16, D. C.

Wanted.—Physician to take over practice in northwestern Pennsylvania. Established for 40 years. Office equipment including full stock of drugs for sale. Centrally located in town of 3000. Large country practice surrounding. Thriving industries, two railroads, general and county hospitals near. Write Dept. 174, PENNSYLVANIA MEDICAL JOURNAL.

Opportunity.—There is an opening for a physician to do mining practice and general practice in district 15 miles from Waynesburg, Pa. It is a nice country district, well populated. Pay from miners and company \$11,000 per year. Income from general practice in addition should equal about half of that from miners and company. Write Dept. 177, PENNSYLVANIA MEDICAL JOURNAL.

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BOOK REVIEWS

Photoradiography in Search of Tuberculosis. By David W. Zacks, M.D., Chief of Clinics, Massachusetts Department of Public Health. Baltimore: The Williams & Wilkins Company, 1949. Price, \$5.00.

This book is an attempt to record the experience of the author in the planning and execution of mass chest x-ray surveys. It deals with organization, personnel, and operation of mobile units. The text delves rather completely into the above three aspects, and includes a discussion of the clerical staff, office space, medical personnel, types of mobile units, methods of preparing the community for the arrival and operation of the mobile units, education of the public regarding mass surveys, and technical factors concerning the production of satisfactory radiographs.

The problems of viewing and interpreting small chest x-ray films are considered, as well as follow-through, follow-up, and disposition of persons with suggestive x-ray abnormalities in the chest. The role of the general practitioner and the industrial physician in the chest x-ray survey procedure is discussed. Suggestions are made for standards in the management of persons with chest abnormalities by chest x-ray clinics. Health education is stressed in attaining communal cooperation and individual consent. The cost of a mass chest x-ray survey is also included.

The latter section of the book contains an atlas of radiographs showing typical cases of minimal pulmonary tuberculosis, normal radiographs, extraneous shadows of clothing, phantoms, pulmonary calcification, rib abnormalities, silicosis, mediastinal abnormalities, abnormalities in the position and configuration of the diaphragm, and cardiac abnormalities.

This volume is a definite asset to those individuals, committees, and organizations engaged in the direction of mass chest x-ray surveys.

Fundamentals of Otolaryngology. A Textbook of Ear, Nose, and Throat Diseases. By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School, and associates. 443 pages with 184 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$6.50.

Dr. Boies and his associates are to be congratulated upon the style and general plan of this textbook. It is easy to read and study, giving all the essentials yet omitting superfluous details which would be of interest only to those specializing in otolaryngology. The au-

thors have been liberal with the use of clear-cut original illustrations, which are especially helpful to the student of otolaryngology. Under each part of the text—ear, nose, and throat—the following subject matter is considered: applied anatomy, physiology, methods of examination, pathology, etiology, symptomatology with diagnosis and treatment (medical and surgical). This textbook is especially recommended to medical students and general practitioners.

May's Manual of Diseases of the Eye. For Students and General Practitioners. Twentieth edition, revised and edited by Charles A. Perera, M.D., Assistant Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Associate Attending Ophthalmologist, Presbyterian Hospital, New York. With 378 illustrations including 32 plates and 93 colored figures. Baltimore: Williams & Wilkins Company, 1949. Price, \$5.00.

This classic text of diseases of the eye continues to be, as Dr. May originally intended, a concise manual of particular value to the medical student and general practitioner. This twentieth edition has been completely revised. There are many new illustrations. Dr. Perera continues to present the fundamentals of ophthalmology in this text, and has brought it up to date with discussions of newer therapeutic measures and surgical procedures.

Clinical Neurology. By Bernard J. Alpers, M.D., Sc.D. (Med.), Professor of Neurology, Jefferson Medical College, Philadelphia; Neurologist to the Jefferson, Pennsylvania, and Wills Hospitals, Philadelphia. Second edition. 862 pages with 240 illustrations and 58 tables. Philadelphia: F. A. Davis Company, 1949. Price, \$9.50.

Dr. Alpers' first edition in 1945 was criticized largely because of the carelessness shown in typographical errors, poor grammatical construction, misspelling of proper names, numerous contradictions, and unnecessary redundancies. The same criticism applies to the second edition. Very few corrections have been made and additional errors appear in the revision. However, the appearance of a second edition attests to the esteem in which Dr. Alpers is held for his knowledge, clinical experience, and judgment.

From the table of contents to the index there has been an improved coordination of subject matter, paragraphs, and an attempt to make the text more easily

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readable. Etiologic concepts and mechanisms have been enlarged in these topics: headaches (head injury, migraine, histamine), neuritis (diabetic, median nerve), scalenus anticus syndrome and shoulder pain, epilepsy (metabolic changes, dietary influence of nitrogen trichloride, and hereditary factors), mode of transmission in acute anterior poliomyelitis, vasoparalysis theory of Scheinker in cranial trauma, and intra-uterine influence in Little's disease. Cortical localizations in stereognostic perception and suppressor areas are also introduced.

The part devoted to neuropathology, especially the illustrations of specimens, is excellent. Sections on neurosyphilis, brain abscess, and meningitis have been rewritten to include antibiotic therapy, and the Kenny treatment in acute anterior poliomyelitis is minimized. The use of mesantoin and the more widespread use of tridione in epilepsy are included. Other new drugs include DHE⁴S in migraine, parpanit in paralysis agitans, guanidine or potassium chloride in myasthenia gravis. X-ray irradiation is recommended in spondylarthrititis ankylopoietica as well as ablation of the opposite motor cortex in hemiballismus. World War II experience with nerve injuries and cranial trauma has also been added.

The author has added the following new topics to his textbook: cutaneous diphtheria, infectious hepatitis, and mononucleosis as producing neuritis; symptoms of central nervous system complication in infectious hepatitis, brucellosis, and schistosomiasis; fat embolism in cerebrovascular diseases; occlusions of basilar, postero-inferior cerebellar arteries; eosinophilic granuloma of bone in skull tumors; and the possibilities of intoxication of the nervous system from the use of gold preparations, antibiotics, and anticonvulsants.

The book is intended primarily for students and general practitioners, but neuropsychiatrists can also use it with much profit in preparing for certification or as a reference source for their current diagnostic problems.

Atlas of Obstetric Technic. By Paul Titus, M.D., Obstetrician-Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Secretary, American Board of Obstetrics and Gynecology. Illustrations by E. M. Shackelford, formerly Medical Illustrator, John C. Oliver Memorial Research Foundation, St. Margaret Memorial Hospital, Pittsburgh. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$7.50.

The second edition of Dr. Titus' *Atlas of Obstetric Technic* contains many revisions of his previous fine book. The sequence of chapters is rearranged to follow the patient through her antepartum and postpartum periods, as well as labor and delivery. Some of the chapters have undergone revision and new concepts and advances are incorporated. Sections dealing with antepartum care and analgesia and anesthesia are newcomers.

As its name implies, this book is an atlas, designed to supplement the author's other book, *The Management of Obstetric Difficulties*, or any other standard textbook of obstetrics. Drawings replace lengthy descriptions, and controversial discussions are absent. Its terseness and easy reference make it a valuable addition to the library of all who practice obstetrics.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Life Among the Doctors. By Paul De Kruif. In collaboration with Rhea De Kruif. New York: Harcourt, Brace and Company, 1949. Price, \$4.50.

Allergy in Relation to Otolaryngology. By French K. Hansel, M.D., M.S., F.A.C.A., Editor-in-Chief, *Annals of Allergy*; Director of The Hansel Foundation; Associate Professor of Otolaryngology, Washington University School of Medicine. Panel Discussion: Harold A. Abramson, M.D., Kenneth L. Craft, M.D., Jerome Glaser, M.D., Irving B. Goldman, M.D., M. Martyn Kafka, M.D., Granville F. Knight, M.D., Hugh A. Kuhn, M.D., John H. Mitchell, M.D., Walter E. Owen, M.D. An official publication of the American College of Allergists. St. Paul and Minneapolis: Bruce Publishing Company, 1949. Price, \$2.50.

X-ray Treatment. Its Origin, Birth, and Early History. By Emil H. Grubbe, B.S., M.D., F.A.C.P., Charter Member and Emeritus Member of the Radiological Society of North America; Charter Member of the American Roentgen Ray Society; Diplomate of the American Board of Radiology; Associate Fellow of the American Medical Association; Emeritus Member of the Illinois State Medical Society; and a member of the Chicago Medical Society. St. Paul and Minneapolis: The Bruce Publishing Company, 1949. Price, \$3.00.

For the New Mother. By Mildred V. Harcastle, R.N. Illustrated by Shirley Tattersfield. Philadelphia: The John C. Winston Company, 1949. Price, \$2.00.

Gynaecological Histology. By Josephine Barnes, M.A., D.M. (Oxford), M.R.C.P. (London), F.R.C.S. (England), M.R.C.O.G. (Assistant, Obstetric Unit, University College Hospital, London; Assistant Obstetrician and Gynaecologist, Elizabeth Garrett Anderson Hospital; Surgeon, Marie Curie Hospital); Mem-bre correspondent, Societe Francaise de gynecologie. With 162 illustrations. New York: Grune & Stratton, 1949. Price, \$6.50.

Clinical Diagnosis by Laboratory Examinations. By John A. Kolmer, M.D., M.S., Dr.P.H., Sc.D., LL.D., LL.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry of Temple University; Director of the Research Institute of Cutaneous Medicine; formerly Professor of Pathology and Bacteriology in the Graduate School of Medicine of the University of Pennsylvania. Second edition. New York: Appleton-Century-Crofts, Inc., 1949. Price, \$12.00.

The Eye and Its Diseases. By 92 international authorities. Edited by Conrad Berens, M.D., F.A.C.S., Managing Director of the Ophthalmological Foundation, Inc.; President, Snyder Ophthalmic Foundation; President, American Academy of Ophthalmology and Otolaryngology; Diplomate and former Member, American Board of Plastic Surgeons; President, Pan-American Association of Ophthalmology; formerly President of the Section on Ophthalmology of the American Medical Association; Fellow of the American Ophthalmological Society; Fellow of the American Illuminating Engineering Society; Fellow of the Aero-Medical Association; Vice-President, National Society for the Prevention of Blindness; Vice-President, International Society for the Prevention of Blindness. Second edition, with 436 illustrations, 8 in color. Philadelphia: W. B. Saunders Company, 1949. Price, \$16.00.

STUDY EFFECTS OF MILITARY SERVICE
ON RECLASSIFIED MEN

Nearly all of a group of 303 men reclassified 1A in 1943, after originally having been rejected for military service because of heart and blood vessel defects, were in good health in 1947, a study made by special cardiovascular boards in five major cities shows.

The study was made under contract to the Army Research and Development Board, Office of the Surgeon General. Reports of the re-examination of men disqualified by local boards and induction stations because of a diagnosis of cardiovascular defects were made public in 1943. The re-examination was made by special medical advisory boards consisting of cardiovascular experts in Boston, Chicago, New York, Philadelphia, and San Francisco, in cooperation with the state and city directors of Selective Service.

Of the total number of 4994 cardiovascular rejectees re-examined in 1943, 863 (17.3 per cent) were resubmitted as 1A. Chicago yielded the lowest salvage (3.88 per cent), probably because cardiovascular experts had already been used freely in the decision about doubtful cases.

Reporting on the 1947 study in the April 16 *Journal of the American Medical Association*, Paul D. White,

M.D., Boston, Robert L. Levy, M.D., New York, William J. Kerr, M.D., San Francisco, William D. Stroud, M.D., Philadelphia, and George K. Fenn, M.D., Chicago, say:

"In general, the 303 men served long and well in the armed forces, even though a few were discharged for cardiovascular reasons. Eight of the 447 original rejectees who were accepted for service were killed in action."

Only 303 of the group of 447 could be located for study in 1947.

"In 1947 almost all the men re-examined were in excellent or good health (259 of the 303) and were working. Only four were actually disabled.

"Lesions indicating rheumatic heart disease, not evident in 1943, were noted in four men in 1947. Many others gave a history of rheumatic fever in childhood or early adult life, but showed no sequelae.

"Heart murmurs were the commonest cause for the original rejections. The great majority of the murmurs were variable, unimportant, and physiologic in type, being heard in at least half of these healthy young men.

"Of the 67 men showing transient high blood pressure in 1943, 33 showed normal pressure readings, 17 still showed transient high blood pressure, and 17 had sustained high blood pressure in 1947. Thirteen with normal pressure in 1943 showed transient high blood pressure in 1947, and in ten sustained high blood pressure developed.

"Of 35 with transient tachycardia (heart rate over 100 subsiding after thirty minutes' rest) in 1943, 19 showed no tachycardia in 1947. In a few cases the reverse was true. Another study has shown that transient high blood pressure and transient tachycardia are of about equal prognostic importance with regard to the later development of sustained high blood pressure.

"Heart size showed only minor variations, up or down, between the examinations in 1943 and those in 1947. In only four men did definite enlargement of the heart develop. Electrocardiography also presented little difficulty. There were a few borderline cases noted on both occasions, but only one showed a distinct abnormality at the end of the four years.

"Neurocirculatory asthenia was an uncommon development over the four-year period—there were seven men whose conditions were so diagnosed in 1947 who were considered normal in 1943."

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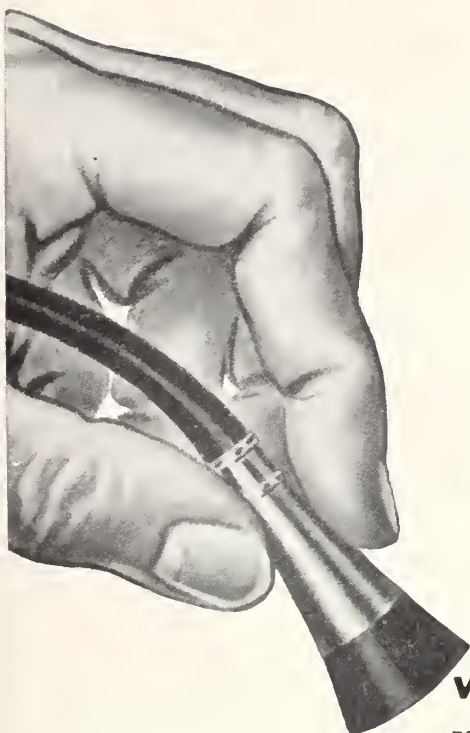
Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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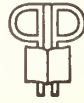
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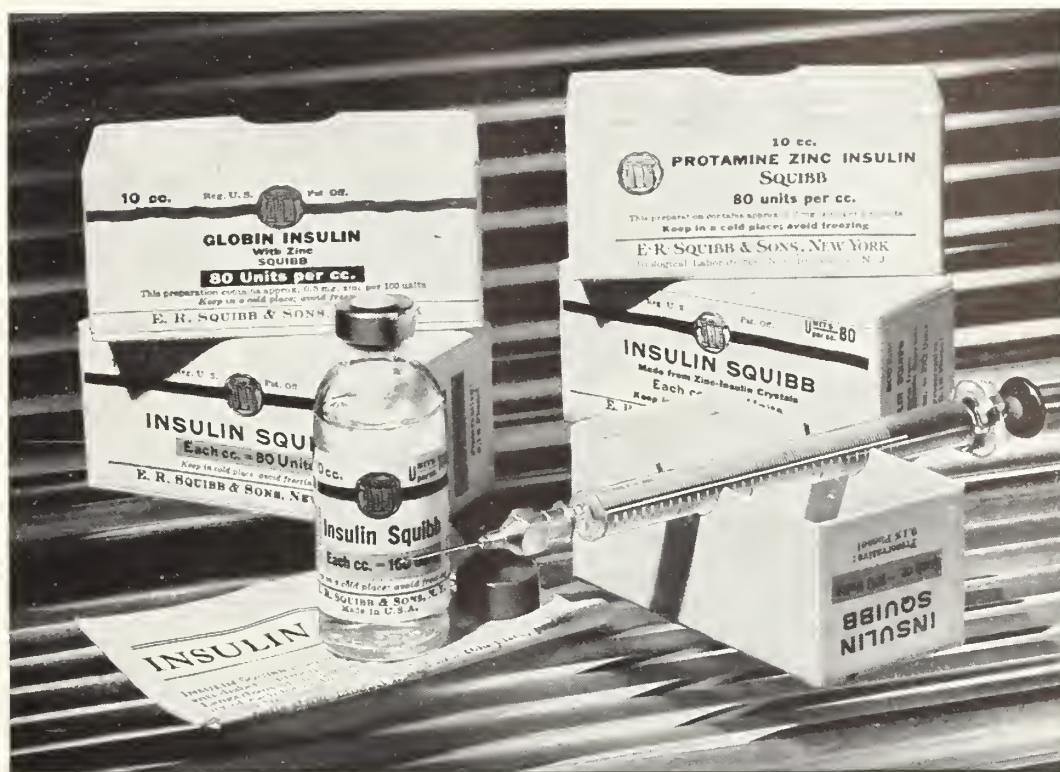
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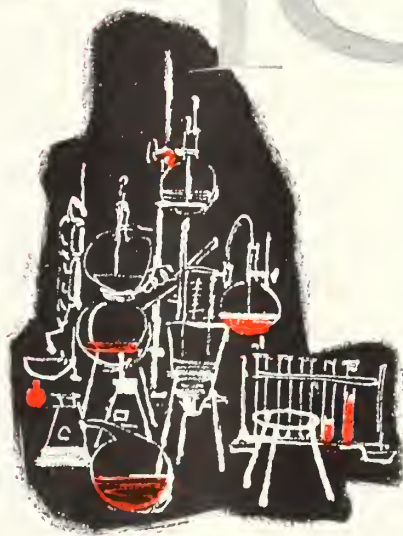
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LETTERS

Religious Hour

GENTLEMEN:

Thank you very much for your letter.

We were happy to take part in your society's "Religious Hour." Your check will be deposited to the choir's account in the University treasurer's office where it will be useful in helping to take care of the expenses of our activities.

Again may I express gratitude for your thoughtfulness.

Sincerely yours,

THEODORE M. FINNEY, D.D., *Director*,
Heinz Chapel Choir.

GENTLEMEN:

Thanks for your letter and the enclosure. It was a real privilege to speak to the convention in the Heinz Chapel yesterday and I do appreciate their kindness in asking me.

Sincerely,

HOWARD C. SCHARFE, D.D., *Pastor*,
The Shadyside Presbyterian Church.

GENTLEMEN:

Thank you very much for your letter and its generous enclosure. I am grateful to the Medical Society for its thoughtfulness and I want you to know that I was greatly honored to participate in the service.

The large attendance, which I am told was the largest ever at a service in the chapel, indicated that such a service has significance for The Medical Society of the State of Pennsylvania.

Sincerely,

RABBI SOLOMON B. FREEHOF, D.D.,
Rodef Shalom Temple.

GENTLEMEN:

I was sufficiently honored by just being a part of a service for a group that ranks tops in my list of professions. It was a pleasure to welcome you to the Heinz Chapel.

Please be assured of my gratitude both for the planning and the program and for the generous honorarium.

Sincerely,

RAYMOND F. BRITTAIN, D.D., *Chaplain*,
Heinz Chapel,
University of Pittsburgh.

Best Article

GENTLEMEN:

The article "Socialized Medicine as I Saw It" (appearing in the December PENNSYLVANIA MEDICAL JOURNAL) impressed me as being the best article that I have seen for American free-enterprise medicine as against compulsory state medicine, as proposed by Pres-

ident Truman and Company. Is it possible to get reprints of this article to distribute to private patients?

Very truly yours,

_____, M.D.,
Pennsylvania.

Electrocardiography Course

GENTLEMEN:

I would appreciate your expressing to the committee my gratification for the course in electrocardiography recently completed in Harrisburg. The presentations of Drs. Durant, Quickel, Smith, and Faller are deserving of the highest praise.

I hope the committee will see fit to continue this course and perhaps add others to it.

ROLAND A. LOEB, M.D.,
435 West Chestnut St.,
Lancaster, Pa.

GENTLEMEN:

The course in electrocardiography presented in Harrisburg by the Commission on Graduate Education of The Medical Society of the State of Pennsylvania is equal to a postgraduate course in a university, and of great value not only to beginners but to those practitioners experienced in electrocardiography.

These lectures make it easy to follow the text in an intelligent manner and to interpret the findings shown on the mounted electrocardiograms.

The general practitioner will find this course of great help in his everyday practice and it deserves the support of every general practitioner in the State. The course will keep any doctor of medicine well informed on the current medical literature and will refresh him on physiology, diagnosis, and therapeutics.

Drs. Durant, Smith, Quickel, and Faller have done a splendid job and to better express what I think of the course I will add that I want to take it over again.

ROBERT P. BANKS, M.D.,
Mifflintown, Pa.

This popular electrocardiography course is being repeated in Harrisburg on May 11, 18, 25, June 1, 8, 15, and 22. The registration fee is \$35 and registrations are limited to 60. The only announcement of this course will be made through the JOURNAL. A registration form appears on page 153 of this issue. If you want to be one of the 60 to take this course, you should register now.—THE EDITORS.

Unique

GENTLEMEN:

You were very kind to send me a check in the amount of \$50.00 as an honorarium for my services to

the Graduate Education Institute during the fall sessions in 1949. However, I am taking the liberty of returning this check to you and ask that it be assigned to some fund or to the Society in general toward the purposes for which it could best be used. I do not feel that the small effort on my part in promoting this excellent program of the Society should be compensated. Rather, I am flattered and pleased that I was asked by your committee to participate.

Sincerely yours,

_____, M.D.

Pennsylvania.

AMA Dues

GENTLEMEN:

In the payment of my 1950 dues in full, I enthusiastically endorse the inclusion of AMA dues.

_____, M.D.

Pennsylvania.

Literature Limited

GENTLEMEN:

Thank you very much for your courtesy in sending the JOURNALS to me. It was indeed kind of you. I have enjoyed reading them a great deal and so have the other doctors on my staff. Our medical literature here (Northern Honshu, Japan) is somewhat limited.

LT. COL. STUART P. VANDIVIERE, M.C.,
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PROTEIN.....	32 Gm.	VITAMIN B1.....	1.16 mg.
FAT.....	32 Gm.	RIBOFLAVIN.....	2.0 mg.
CARBOHYDRATE.....	65 Gm.	NIACIN.....	6.8 mg.
CALCIUM.....	1.12 Gm.	VITAMIN C.....	30.0 mg.
PHOSPHORUS.....	0.94 Gm.	VITAMIN D.....	417 I.U.
IRON.....	12 mg.	COPPER.....	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



Surgical Aspects of Gastric and Duodenal Ulcer

JOHN D. STEWART, M.D., HARRY W. HALE, Jr., M.D., and
JAMES E. HIX, M.D.
Buffalo, N. Y.



Dr. Stewart

GASTRODUODENAL Ulcer is a problem which presents a challenge to various specialists, and the best results come from a pooling of clinical talent. The surgeon is concerned with therapy, and since this is so it behooves not only the surgeon but the other members of the team concerned with gastroduodenal ulcer to keep in mind at all times what can reasonably be expected of surgical treatment. The continuous increase in knowledge which provides a physiologic basis for corrective surgery in peptic ulcer, the great progress in preoperative and postoperative care, and the advances in surgical technique and anesthesia make it necessary to revise standards of value frequently if the patient is to be advised properly. When the internist considers the therapeutic weapon that his surgical colleague can put at his disposal, he must consider its present worth, not that of a decade ago. It may not be amiss also to point out that surgical skill and surgical facilities, like efficiency in radiologic or gastroscopic diagnosis, or success in keeping a patient on an

effective medical regimen in the management of ulcer are variable factors in different hands. Therefore, the treatment of choice for the same lesion logically may vary in different hands and in different communities.

Though the basis for effective gastric surgery was laid by the contributions of European surgeons, recent improvements in methods have come from the work of such surgeons as A. W. Allen, Lahey, W. Walters, McKittrick, Wangensteen, R. Graham, and Dragstedt. There has evolved the present type of highly satisfactory gastric resection for ulcer, in which the following principles are observed: (1) at least two-thirds of the stomach is removed; (2) all the gastric mucosa at the pyloric outlet is ablated; (3) the ulcer itself is excised whenever possible; (4) the jejunal loop anastomosed to the gastric residue is as short as it can be without undue tension on the anastomosis; (5) the duodenal and gastric stumps are mobilized sufficiently to permit adequate layered closure. In addition, many surgeons can attest to the value of the Hofmeister procedure of carrying the resection high on the lesser curvature with closure of that aspect of the gastric stump and anastomosis only at the greater curvature. This operation can be performed, even in depleted patients, with a risk of less than 2 per cent. Such postoperative complications as hemorrhage, gastric retention, and peritoneal infections are rare. Marginal ulcer and recur-

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From the University of Buffalo Medical School and the Meyer Memorial Hospital, Buffalo, N. Y.

TABLE I

Associated diseases in 120 consecutive gastric resections for complications of peptic ulcer (excluding acute massive hemorrhage).

Heart disease	18
Hypertensive	9
Arteriosclerotic	5
Rheumatic	3
Syphilitic	1
Pulmonary disease	17
Active tuberculosis	7
Emphysema	6
Bronchiectasis	1
Pulmonary fibrosis	1
Kyphoscoliosis	2
Malnutrition and avitaminosis	30
Ascites (at operation)	4
Miscellaneous	51

rence of peptic ulcer after this type of operation are no longer a problem. Our own preference is for the antecolic Hofmeister type of anastomosis and as shown by a series of measurements an average of 80 per cent of the stomach is removed. The gastrojejunal stoma in diameter approximates the caliber of the jejunum and averages 5.7 cm. in external measurement, or about 3 cm. internally. The patients are out of bed and walking within 24 hours, they are taking a six-meal bland diet within ten days, and they leave the hospital within two weeks (average figures). Within six months the patients are unrestricted in diet.

In our current experience with this operation in a group of patients suffering from non-hemorrhagic complications of gastric or duodenal ulcer, there have been 120 consecutive cases without a death. The incidence of associated diseases is shown in Table I. The average age of the group was 51.4 years and two patients were over 80 years. In the series of cases there had been 34 previous operations of some sort for peptic ulcer. In 62 per cent of the cases the ulcer was duodenal, in 23 per cent it was gastric; 12 per cent of the patients had both duodenal and gastric ulcer, and in 3 per cent the ulcer was marginal following old gastro-enterostomy. In 38.2 per cent of the cases gastric obstruction was present, and in 47.8 per cent the ulcer was found at operation to have penetrated into neighboring viscera. The postoperative complications in the group of cases are tabulated in Table II. These involved chiefly the respiratory system, and in no instance was convalescence delayed more than one week.

The above data are cited to emphasize the fact that subtotal gastrectomy for ulcer complications can be done with small danger even in poor-risk cases. Similar results are being reported in the current literature from various other clinics.^{1, 2, 3, 4} Garlock and Lyons⁵ have recently recorded a series of 116 consecutive gastric resections for duodenal ulcer without a death. Parenthetically, I should like to state that we have had only a small experience with vagotomy in the treatment of peptic ulcer, and our experience has been meager for two reasons: first, subtotal gastrectomy gives satisfactory early and late results in our hands, and second, it seems only fair to await the final definitive appraisal of vagotomy by Dragstedt.

In considering the immediate results of subtotal gastrectomy, some interest centers in the so-called "dumping syndrome." This has been present in mild form in about 10 per cent of our cases, and the symptoms have subsided as a rule within three months. Nausea, weakness, flushing, cold sweat, and palpitation comprise the symptomatology, and whether due to jejunal distention, duodenal reflux, or hypoglycemia the symptoms suggest autonomic mediation. There is some evidence that reducing the size of the gastrojejunal stoma lessens the frequency and severity of such symptoms, which is one reason we prefer the Hofmeister type of anastomosis. The recent work of Porter and Claman² offers strong support for this impression.

In discussing the indications for subtotal gastrectomy in the management of peptic ulcer, it becomes necessary at once to separate gastric

TABLE II

Postoperative complications in 120 consecutive gastric resections for peptic ulcer (excluding operations for acute massive hemorrhage). There were no deaths.

Lungs	31
Atelectasis	17
Pneumonia	12
Pleurisy	1
Pulmonary edema	1
Circulation	8
Pulmonary embolism	2
Thrombophlebitis	6
Wound	5
Dehiscence	2
Infection	3
Gastro-intestinal tract	11
Postoperative bleeding (mild)	1
Diarrhea	8
Stomal obstruction (mild)	2

TABLE III

Comparison of results of non-surgical and surgical treatment for acute severely bleeding peptic ulcer (patients with 40 per cent exsanguination or greater).

Treatment	Number	Deaths	Mortality Rate
Non-operative . . .	36	9	25.0%
Gastric resection .	41	6	14.6%

from duodenal ulcer. It is usually estimated that from 80 to 85 per cent of patients with duodenal ulcer can be treated satisfactorily without surgery. Probably the proportion requiring surgical treatment is even lower than 15 to 20 per cent, for undoubtedly a great many patients with duodenal ulcer seek no medical aid, and the diagnosis is not made. There is fairly general agreement that the complications of duodenal ulcer which require surgical treatment are perforation, fibrosis and obstruction of the lumen, recurrent hemorrhage, and intractability. Intractability to treatment in our experience is usually associated with penetration of the ulcer into adjacent structures and formation of extraluminal craters. In such instances it is no longer duodenal ulcer alone, but inflammatory disease in neighboring organs as well which must be treated. Another group of patients come to subtotal gastric resec-

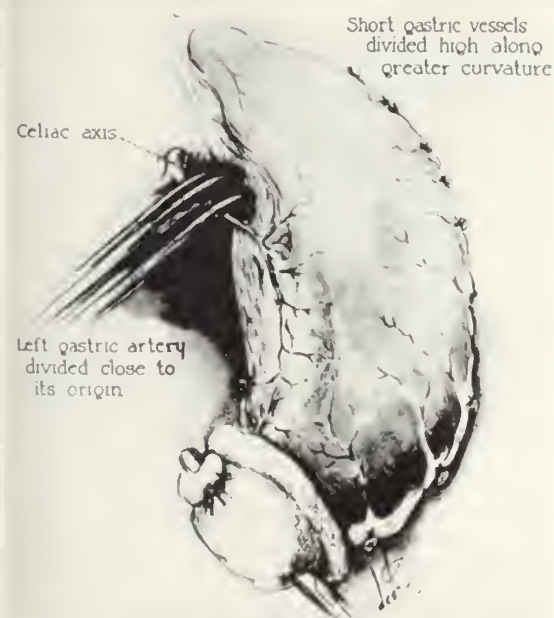


Fig. 1. Mobilization of stomach and proximal duodenum with control of blood supply.



Fig. 2. Technical steps for Hofmeister anastomosis.

tion not because the duodenal ulcer fails to respond to medical treatment but because the patients are unwilling or unable to follow the wise counsel of the internist. Personal irresponsibility or unfavorable economic or environmental conditions thus may lead to operation. All the complications which lead to surgery in the case of duodenal ulcer may occur in gastric ulcer, but the hazard of cancer must be added to the picture.

The remainder of this discussion will deal with two somewhat controversial concepts: first, that acute life-endangering hemorrhage from either gastric or duodenal ulcer demands immediate blood replacement and gastric resection, and second, that any gastric ulcer persisting as long as a month under medical management in the hospital should be treated by gastric resection.

There is general agreement that gross hemorrhage is the commonest complication of peptic ulcer. In 692 admissions of patients with peptic ulcer to the medical and surgical services of the Meyer Memorial Hospital during a six-year period, obvious hemorrhage was the presenting symptom in 146, or 25.5 per cent. Perforation was responsible for only 9.1 per cent of the admissions for peptic ulcer during the same period. Duodenal ulcer was approximately four times as common as gastric ulcer and showed about the same liability to hemorrhage. Females were about one-quarter as numerous as males in the

series, but the proportion admitted for hemorrhage was about the same. Fifty-seven per cent of the patients admitted for bleeding had not bled grossly before; 30.3 per cent were having their second episode of bleeding, and 12.9 per cent had bled two or more times previously.

In analyzing the effectiveness of treatment of overt hemorrhage from gastric or duodenal ulcer as reported in various studies, it is difficult to arrive at convincing conclusions. The quality of treatment provided, including the amount of blood transfused, has varied and often medical treatment has given way to late and desperate surgery in a so-called combined medical and surgical management. The degree of blood loss has varied in different cases and proper laboratory data have usually not been obtained by which severity of anemia and oligemia could be appraised. The term "massive" has been indiscriminately and loosely used with quantitative implications. Another uncertain point has been the duration of bleeding before admission to hospital. Where surgical treatment has been provided, it has varied greatly in nature and in timing, and frequently only the moribund patients have been operated upon.

Because of the frequency and danger of this complication, and because of the confusion as regards its proper treatment, we undertook a study of the problem, beginning January 1, 1947, with the cooperation of Dr. David K. Miller, head of the medical service at the Meyer Memorial Hospital. The plan of study and treatment has been as follows: only the severely bleeding patients were included in the study, and all met the following criteria: (1) the patient had bled grossly into the upper gastro-intestinal tract within one week of admission to the hospital, as manifested by vomiting blood and passing tarry stools with attendant signs of cerebral anemia; (2) the admission red blood cell count was 2.5 million cu. mm. or less, or the total circulating red cell mass, as determined by blood volume measurements, was 60 per cent or less of normal; (3) there was reasonably good clinical evidence for the diagnosis of peptic ulcer—other affections, including hemorrhagic blood diseases, having been excluded.

These patients have then been divided into two groups. About half have been operated upon within 48 hours after admission, the average delay being nine hours, and an average of 3.5 liters of blood being given before and during operation.

The operation has consisted of the standard 80 per cent gastric resection described above. The rest of the cases, largely consisting of those who preferred not to be operated upon, have been treated as control cases according to accepted medical principles, including free use of blood transfusion and feeding liquid and solid food as soon as tolerated. Cases of less extensive hemorrhage were not included in the series, and I wish to stress the point that we were concerned only with cases of dangerous exsanguination as shown by specific measurements. It became apparent early that determination of blood volume was essential to evaluation of the case, for vasoconstriction and retarded hemodilution in some patients may result in maintenance of the red cell count for hours after total blood volume has been seriously depleted.

The study is still in progress, but as shown in Table III the results to date support early blood replacement and gastric resection as being the treatment of choice in our clinic. In the last 33 consecutive gastric resections in these acutely exsanguinated cases there was one death. It should be emphasized that the operation carried out, subtotal gastrectomy, is the same as that used under less critical conditions, and therefore not only is control of hemorrhage achieved but also definitive treatment for the ulcer diathesis. It is worthy of note that during the same period two patients who otherwise met the criteria mentioned above had gastric resection performed for malignant ulceration of the stomach, one cancerous, the other lymphosarcomatous, though they are not included in the tabulation. Both had an uneventful convalescence.

The early treatment of severely bleeding peptic ulcer by subtotal gastrectomy makes many demands on the hospital staff and facilities. Unless suitable laboratory and transfusion facilities, surgical experience, an efficient surgical resident staff, and excellent anesthesia service are at hand, probably a medical regimen is to be recommended instead. Obviously each clinic should treat these desperately ill patients according to the method which yields best results in its own hands. Unless a careful testing of different methods is made, however, with definition of criteria and proper use of control cases, one is hardly in a position to argue the merits of non-surgical as against surgical management of acutely bleeding gastric and duodenal ulcer. This point has re-

TABLE IV

Criteria for selection of cases in study of management of acute massive hemorrhage from peptic ulcer. About half the patients are treated by immediate gastric resection; about half are treated as controls.

1. Gross bleeding within one week.
2. Initial red cell count 2.5 million/cu. mm. or less and/or total circulating red cell mass less than 60 per cent of normal.
3. Reasonably good evidence for the diagnosis.

cently been emphasized by White and Chalmers⁶ in an excellent report on gross hematemesis.

In some instances of severe upper gastro-intestinal bleeding it is difficult to determine the source of bleeding, and the problem of treatment is correspondingly more complicated. White and Chalmers in studying 400 cases of gross hematemesis from a large general hospital found that in 9.5 per cent the diagnosis was unknown despite various tests, including in some cases operation or autopsy. In our experience the bleeding ulcers have been shallow and without palpable induration or detectable serosal reaction in about 15 per cent of the cases. Not much can be expected of radiologic diagnosis in such cases, and yet lethal hemorrhage may occur. In our diagnostic work-up we are specially concerned with excluding primary blood dyscrasia and cirrhosis of the liver with esophageal varices, for together with peptic ulcer these will comprise more than 90 per cent of the cases of severe upper gastro-intestinal bleeding.

As previously mentioned, the indications for subtotal gastrectomy must be considered in a somewhat different light when gastric ulcer rather than duodenal ulcer is known to be present. Walters⁴ reports that whereas only about 15 per cent of patients with duodenal ulcer are operated upon at the Mayo Clinic, 60 to 70 per cent of those with supposedly benign gastric ulcer are treated by subtotal gastrectomy. Welch and Allen¹ in one of the most informative and authoritative reports available on gastric ulcer recommend gastric resection in 75 per cent of patients with gastric ulcer. They state that in 295 gastric resections for supposedly benign gastric ulcer, 32 or 10.8 per cent were cancerous. Similar figures have been reported from the Mayo Clinic, the Lahey Clinic, and from various other clinics, despite the use of the most expert radiologic and gastroscopic methods of diagnosis.

Eusterman⁷ pointed out that small ulcerating

forms of gastric carcinoma not only may be clinically indistinguishable at times from chronic benign ulcer but they may respond to medical treatment so favorably as to give a wrong impression of their true nature. Jordan⁸ has emphatically warned that the three criteria, size of ulcer, age of patient, and presence or absence of free hydrochloric acid, have no actual or practical value in diagnosis for the individual patient. Walters⁴ noted that the clinical symptoms thought to be pathognomonic of benign gastric and duodenal ulcer had occurred in a third of the cases of carcinoma of the stomach in which operation was performed at the Mayo Clinic, and in 80 per cent of this group there had been temporary effective response to a medical regimen. Amelioration of symptoms and even partial filling in of the ulcer crater as the result of a medical dietary and antacid regimen in ulcer-cancer are not surprising, for free hydrochloric acid is often present in such cases. In about half the cases in our series in which the gastric ulceration removed by subtotal gastrectomy had been considered benign but turned out to be cancerous, the pathologist found a component of benign peptic ulceration present in addition to cancer.

There is hardly a more gloomy picture in medicine than that of gastric cancer. A five-year cure rate of 10 or 12 per cent of the cases amenable to gastric resection must be considered as average or better. Most surgical cures of cancer of the stomach undoubtedly have been the cases in which cancer was an unsuspected finding at operation for supposedly benign ulcer, or, in other words, where resection was performed early in the disease. Logically, therefore, there is keen interest in the detection and removal of

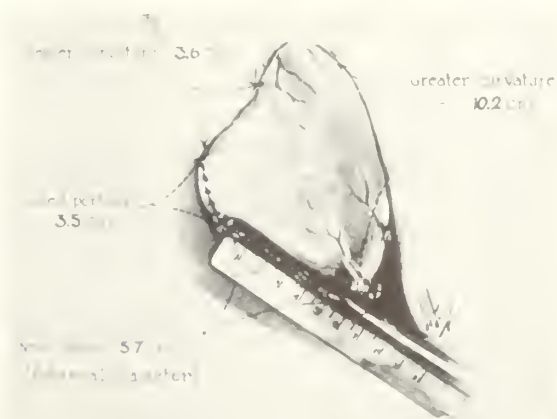


Fig. 3 Average measurements for gastric residue before anastomosis.

precancerous gastric lesions and lesions of uncertain nature.

Since the operative risk of subtotal gastrectomy for supposedly benign gastric ulcer is less than 2 per cent and the cancer hazard is 10 per cent or more, there is rather widespread agreement with the policy which has recently been enunciated by Aaron⁹ and his group as follows: "It is our feeling that the patient with gastric ulcer who does not exhibit freedom of symptoms and roentgenologic evidence of complete healing within four weeks should be operated on." Welch and Allen¹ note that if medical therapy is recommended, such cases must be carefully selected, studied by the best radiologist and gastroscopist available, and followed vigilantly, with early recourse to surgery if healing is not prompt.

It would seem, therefore, that there are grounds for regarding gastric ulcer as a disease to be treated routinely by subtotal gastrectomy, provided satisfactory surgical facilities are at hand. In our opinion it is only the exceptional case which should, for explicit reasons, be treated without operation. The non-surgical management unquestionably places a grave responsibility on the attending physician. Surgical treatment not only offers the best safeguard against gastric cancer but it provides definitive treatment for the ulcer diathesis.

In conclusion and in recapitulation the following principles seem acceptable:

1. Uncomplicated duodenal ulcer can be treated medically with great success and should be so treated.
2. Complicated duodenal ulcer should usually be treated by gastric resection, and often must be so treated.

3. Psychologic or environmental factors may create an indication for gastric resection for duodenal ulcer.

4. Surgical treatment of gastric or duodenal ulcer for its justification requires surgical facilities which make the risk of operation lower than the risk of other methods of treatment, while at the same time offering more effective relief of symptoms.

5. Evaluation of any method of treating gastric or duodenal ulcer requires at least five years.

6. Acute life-endangering hemorrhage from gastric or duodenal ulcer can be treated with satisfactory immediate and late results by early blood replacement and gastric resection if proper surgical facilities are available.

7. Chronic gastric ulcer persisting for as long as four weeks should be treated by gastric resection.

8. Non-surgical treatment of gastric ulcer lays a serious obligation on the attending physician and the patient.

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Evaluation of Function in Pulmonary Disease by Physiologic Tests

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PULMONARY function studies consist of physiologic measurements which permit an appraisal of the ability of the lungs to perform adequately the respiratory gas exchange function. Functional disability may result from many causes, hence a complete history, physical examination, and radiologic study provide information useful in evaluation; however, such clinical information is often inadequate for determination of the extent of the respiratory difficulty. Disability is a loose term which requires a more exact definition than merely "the inability to work," for there are many different types of work, and an individual incapacitated for one job might yet be capable of performing another. In this paper disability will refer solely to the functioning of the lungs with respect to the adequate transport of oxygen from the air to the blood and the removal of carbon dioxide while breathing air, both during rest and exercise. The physiologic tests necessary for the evaluation of pulmonary function impairment will be discussed under five main headings.

Lung and Ventilation Volume Measurements

Ventilation measurements refer to lung volume determinations—vital capacity, maximal breathing capacity, and volume of air breathed per minute both during rest and exercise. Dyspnea (subjective sensation of air hunger) is primarily related to the volume and resistance of air moved in and out of the lungs per unit of time. Vital capacity, although a useful measurement, has but limited value alone. In general the vital capacity decreases as the degree of pulmonary emphysema increases¹ (Fig. 1), but the wide range of in-

dividual variations limits the usefulness of this measurement alone unless the values are extremely low (1500 cc. or less) or very high (above 4000 cc.). A vital capacity of 2000 to 3000 cc. may exist without emphysema or with a far-advanced degree of emphysema (Fig. 1). The percentage decrease from the predicted vital capacity may vary from 0 to 70 per cent in anthracosilicosis, the correlation with the degree of emphysema being poor.^{1, 2}

Maximal breathing capacity (MBC) is the maximal amount of air which can be moved in and out of the chest by rapid deep breathing for short intervals (12 to 24 seconds) stated on a minute basis. The normal values as determined on a modified basal metabolism machine¹ vary from 100 to 150 liters per minute in adult men. Control values for MBC in a group of 20 medical students (age range 20 to 30 years) averaged 161 liters per minute. In anthracosilicosis MBC determinations presented a relationship to the degree of emphysema similar to that of vital capacity (Fig. 2)^{1, 2}; however, in most cases in which the MBC was less than 40 liters per minute a significant degree of emphysema was present, and if the MBC was over 100 liters per minute, the degree of emphysema was insignificant (Fig. 2).

The significance of the MBC measurement when correlated with the degree of pulmonary emphysema was limited in the range from 40 to 100 liters per minute by the wide individual variations. In emphysematous patients the MBC was consistently reduced farther below the predicted value than was the vital capacity.³ MBC appears to have considerable practical value in the early detection of fibrosis with loss of lung elasticity and various degrees of bronchial obstruction. A young individual (20 to 40 years of age) with an MBC less than 100 liters per minute should not be permitted to work exposed to

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From the Cardiorespiratory Laboratory, Barton Memorial Division of Jefferson Medical College Hospital and the Department of Medicine of Jefferson Medical College.

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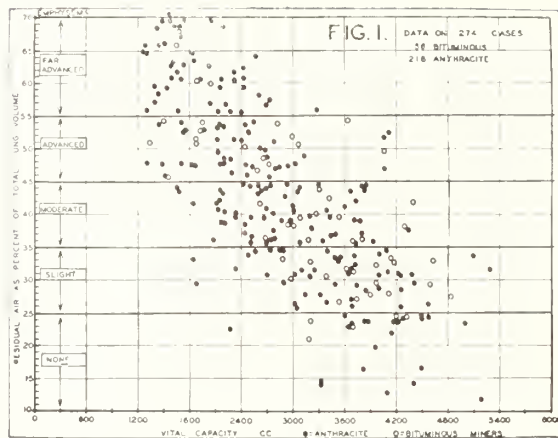


Fig. 1. Correlation of vital capacity and the degree of pulmonary emphysema.² Note the similarity of the bituminous and anthracite data. In general, the vital capacity decreases as the pulmonary emphysema increases. A vital capacity range of 2000 to 3000 cc. may occur with no emphysema or a far-advanced degree of emphysema, and the wide individual variations present limit the usefulness of this measurement in evaluating pulmonary function alone.

silica dust, for if the MBC is less than 100 liters per minute, loss of lung elasticity and breathing obstruction have occurred probably from fibrosis. It would seem desirable to take MBC measurements as a routine procedure along with the chest roentgenogram in industrial workers, for if annual MBC measurements revealed a progressive decrease, fibrosis and loss of lung elasticity with obstruction would be developing, and the individual should be removed from dust hazards regardless of the roentgenologic appearance of the chest.

The minute ventilation volume both during rest and exercise was measured with large gasometers (120 liter and 600 liter capacity). Apprehension and nervousness are often responsible for large increases in the resting minute ventilation, and in most of the subjects, since they were untrained, there was some hyperventilation. The minute ventilation volume *per se* means little unless gas analyses are made and the amount of oxygen uptake and carbon dioxide output calculated. If the amount of oxygen removed from the air breathed is so small that a tremendous volume of air is required to furnish the oxygen requirement for any increase in activity, this measurement becomes significant as a primary factor in disability evaluation. Thus there is an important relationship between the total volume of ventilation and the per cent of oxygen uptake and per cent of carbon dioxide output. The latter aspect will be discussed further later.

The dyspnea following the step-up exercise test was measured by the duration of the subjective sensation of shortness of breath or air hunger after the exercise was stopped. The exercise test referred to in this discussion consisted of 30 step-ups in one minute on a stool 20 centimeters high with the simultaneous collection of the expired air during the minute. Pulse, respiratory rate, and minute ventilation during the step-up exercise test were of little value in disability evaluation. Dyspnea is related principally to the increased movement of air in and out of the lungs and the resulting changes in intrathoracic pressure. In many patients the amount of air per minute required during any exertion was so large that excessively great negative intrathoracic pressures developed during the inspiratory phase accompanied by a subjective sensation of dyspnea. Low O_2 levels of the blood *per se* do not produce dyspnea, but the reflex stimulation produced by the hypoxic condition of the blood increases the minute ventilation volume, which, if of sufficient magnitude, may produce dyspnea as the patient attempts to increase the volume of air moved in and out of the lungs per given unit of time. Since dyspnea is a subjective measurement, the individual variations can be expected to be pronounced and the findings less reliable than in objective tests. As a single measurement, dyspnea is of minor value in disability evaluation unless the duration is markedly extended (three minutes or more).

Pulmonary Emphysema

The degree of pulmonary emphysema was calculated on a quantitative basis by expressing the volume of residual air as per cent of total lung volume (residual air plus vital capacity). After a forced expiration the air still remaining in the lung is called residual air and this normally occupies about 25 per cent of the total lung volume. Residual air was accurately determined by using the oxygen open circuit method⁴ by which duplicate checks of 100 cc. or less were obtained on all patients. The clinical impression of the degree of emphysema in anthracosilicosis was often erroneous when checked against the quantitative measurements.⁵ As previously pointed out, if the residual air was less than 35 per cent of total lung volume, the degree of emphysema was physiologically insignificant.¹ When the volume of residual air constitutes 25 per cent or less of the total lung volume, the lungs as a whole are

not emphysematous, for although there may be small scattered or localized areas of bullae or blebs, they are insignificant in their contribution to the pulmonary function impairment by increasing the mixing and dilution factor. The increased volume of residual air in pulmonary emphysema presents a mixing and dilution problem for each breath of air inhaled. The resulting dilution and impaired mixing decrease the mean partial pressure of oxygen in the alveoli and the oxygen saturation of the blood perfusing the lungs, which blood returns to the left side of the heart unsaturated.

The somewhat arbitrary quantitative classification of emphysema¹ (Table I, Fig. 3) has proved satisfactory for grouping the cases for study and analysis of the data as shown by the close correlation of other measurements altered by the increased volume of residual air, namely, vital capacity, maximal breathing capacity, effective tidal air, alveolar pO_2 , arterial pCO_2 , and mean pO_2 gradient between the inspired air and alveoli.⁶

In anthracosilicosis all degrees of emphysema occur in all age groups (Fig. 3), and apparently no correlation exists between the roentgenologic stage of silicosis and the degree of emphysema either in anthracite or bituminous miners (Table II). In approximately one-third of the cases of anthracosilicosis the degree of pulmonary emphysema was not significant (Fig. 3). In some patients the residual air was increased, yet there was slight disability since the vital capacity was adequate and compensation was maintained with hyperventilation without reaching the dyspnea

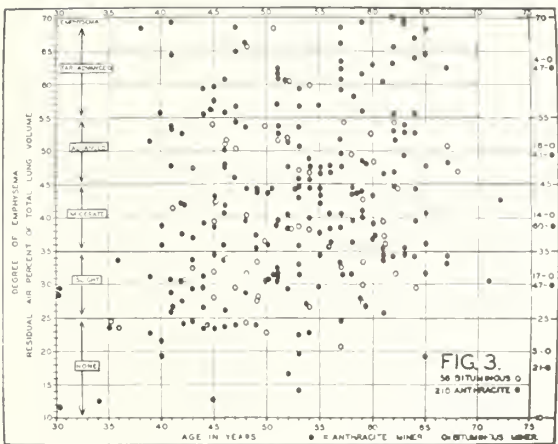


Fig. 3. Correlation of age in years with the degree of pulmonary emphysema. All degrees of emphysema occur in all age groups, both in bituminous and anthracite miners. Each spot represents one case. Note that over one-third of all cases do not have a significant degree of pulmonary emphysema (residual air less than 35 per cent of total lung volume).

level even during mild exercise. However, the increased volume of residual air constitutes a potential hazard in the presence of upper respiratory infections or bronchospasm, as both conditions limit the amount of hyperventilation possible without dyspnea and not only tend to incapacitate the patient during the attack but to delay recovery. In some subjects fibrosis resulted in a progressive marked decrease in vital capacity and total lung volume with the residual air volume remaining approximately at the predicted level or even slightly below. In such cases the residual air may occupy as much as 50 per cent or more of total lung volume and thus contribute to the disability, for in general compensatory hyperventilation was also impaired.

Emphysema of a far-advanced degree is disabling and the evaluation of disability may be made on the measurements which involve two determinations (residual air and vital capacity). A correlation has been noted between the degree of emphysema and the incidence of right heart strain,⁷ and although the correlation of emphysema with right heart strain was definite, the typical electrocardiographic findings are often absent even in cases with far-advanced emphysema. The determination of the degree of emphysema is one of the most important measurements in the evaluation of disability.

Arterial Blood

The arterial blood oxygen saturation (as calculated from oxygen content and capacity determinations on the Van Slyke apparatus) is a very valuable measurement of the pulmonary function

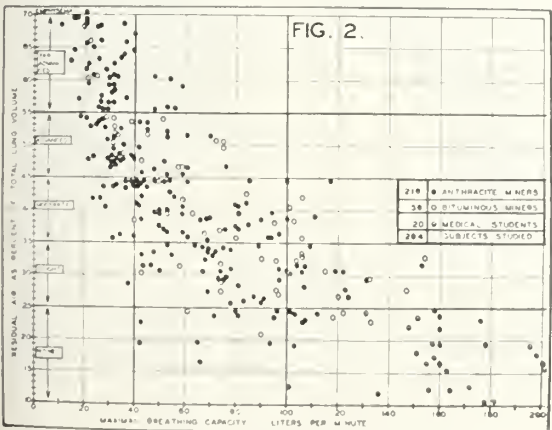


Fig. 2. Correlation of maximal breathing capacity and the degree of pulmonary emphysema. The data on the bituminous and anthracite miners are similar. Note the data on 20 medical students (20 to 30 years of age) used as controls, with an average maximal breathing capacity of 160 liters per minute and a residual air of only 19 per cent of total lung volume.

TABLE I

CLASSIFICATION OF PULMONARY EMPHYSEMA

Measurements used	Example
Vital capacity	(4500 cc.)
Residual air	(1500 cc.)
Total lung volume	(6000 cc.)
Residual air per cent of total lung volume	(25.0)
Degree of emphysema based on the residual air percentage of total lung volume by groups.	
Group 1. None	25% or less
Group 2. Slight	25-35%
Group 3. Moderate	35-45%
Group 4. Advanced	45-55%
Group 5. Far advanced	55% or above
	Degree insignificant
	Degree significant

The above classification of emphysema based on quantitative measurements was used in grouping all cases for study and analysis of the data obtained.

status. The resting arterial oxygen saturation alone is poorly correlated with the degree of function impairment or even the degree of pulmonary emphysema, but a comparison of the exercise arterial oxygen saturation with the resting value was very significant^{2, 6} (Fig. 4). The average resting arterial oxygen saturation has been found for the most part to vary from 90 to 98 per cent with no apparent correlation with the degree of emphysema. In some patients the arterial oxygen saturation improves with moderate exercise, while in others it may decrease as much as 10 to 15 per cent with mild to moderate exercise compared to the resting level—important information for disability evaluation. In general, the more marked the degree of emphysema, the greater the decrease in arterial oxygen saturation with exercise, both in anthracite and bituminous miners.

In patients with an advanced degree of emphysema, exercise produced periods of acute hypoxia, and acute hypoxia even of short duration produced increased pulmonary artery pressure, decreased cardiac output, and increased pulmo-

nary vascular resistance.⁸ Studies on the pulmonary circulation during exercise revealed definite abnormalities in chronic pulmonary disease including limited increase in cardiac output, a rise in pulmonary artery pressure, and an increase in pulmonary vascular resistance as compared to unchanged or lowered pulmonary artery pressure and pulmonary vascular resistance during exercise in normal subjects who have much greater increases in cardiac output.^{9, 10} A decrease in arterial oxygen saturation with exercise is highly significant in disability evaluation, as the acute hypoxia tends to further limit the magnitude of the increase in pulmonary blood flow during exercise and work in the presence of the increased pulmonary vascular resistance imposed by the fibrosis of anthracosilicosis.

There was no apparent means of predicting in advance the changes in the arterial oxygen saturation with exercise, for the normal resting arterial oxygen saturation may be far less than that predicted, and furthermore the resting values themselves exhibited wide individual variations accompanied by only slight average changes when correlated with the degree of pulmonary function impairment. Pulmonary emphysema is a contributing factor in the arterial oxygen unsaturation, for by lowering the mean partial pressure of oxygen in the alveoli the oxygen partial pressure in the blood and the hemoglobin per cent saturation are reduced. If the ventilatory factor (maximal breathing capacity and vital capacity) is greatly reduced, then the lowering of the arterial blood oxygen saturation is more marked for a given degree of emphysema. In anthracosilicosis the resulting fibrosis has been found to produce an unequal alveolar aeration and perfusion¹¹ (known as the distribution factor).

A true diffusion difficulty with increased resistance in the pulmonary membrane is of minor

TABLE II

DEGREE OF PULMONARY EMPHYSEMA VERSUS X-RAY STAGE OF SILICOSIS

Group	Residual Air Per Cent of Total Lung Volume	No. of Cases	Normal or Borderline	First Stage	Second Stage	Third Stage
1	25 or less	30	5	1	10	14
2	25-35	62	6	6	14	36
3	35-45	74	7	9	5	53
4	45-55	60	4	12	11	33
5	55 and above	50	5	8	9	28
Total number		276	27	36	49	164
Per cent of total number		...	9.8%	13.0%	17.8%	59.4%

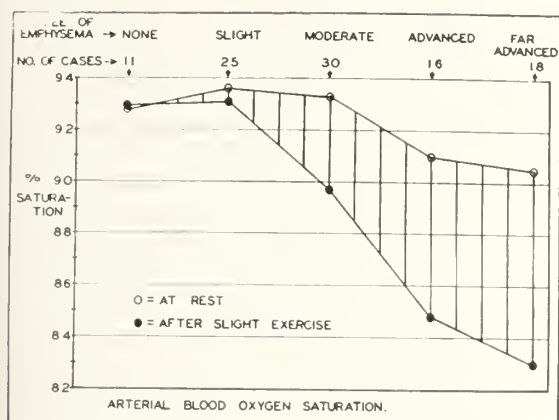


Fig. 4. A graphic representation of the correlation between arterial blood oxygen saturation and the degree of pulmonary emphysema at rest and immediately after exercise. Note that the arterial blood oxygen saturation decreases progressively after slight exercise in patients with a greater degree of emphysema, whereas the resting values show only slight changes. Normal arterial oxygen saturation 96 per cent or more.

significance in lowering the arterial oxygen saturation of blood by increasing the mean gradient of pressure for oxygen from the alveolus to the arterial blood.^{11, 12} Some alveoli are poorly aerated or ventilated as a result of the fibrosis which constricts the respiratory bronchiole and decreases the elasticity of the lung, yet these

alveoli are still perfused with blood, thus the hemoglobin in the blood leaving these alveoli is not completely saturated with oxygen as a result of the impaired circulation of air. In other alveoli the air circulation may be completely blocked subsequent to fibrosis, bronchospasm from the chronic irritation of the silica inhalation or excessive secretions, but these alveoli are still perfused with blood and no gas exchange occurs as the blood circulates through the pulmonary capillaries (acts as a small shunt). All degrees of impairment are present from alveolar ventilation with no perfusion to alveolar blood perfusion but no ventilation. The distribution factor refers to the unequal alveolar aeration and perfusion and the degree of involvement of each varies widely; in some cases the distribution factor may be related almost wholly to the unequal ventilation, while in other cases the major involvement is unequal perfusion.

Hemoglobin determinations are of minor significance, as most anthracosilicotic patients even with a far-advanced degree of emphysema and arterial oxygen unsaturation did not exhibit polycythemia or elevated hemoglobin.⁶ Wood and his associates have described a modified

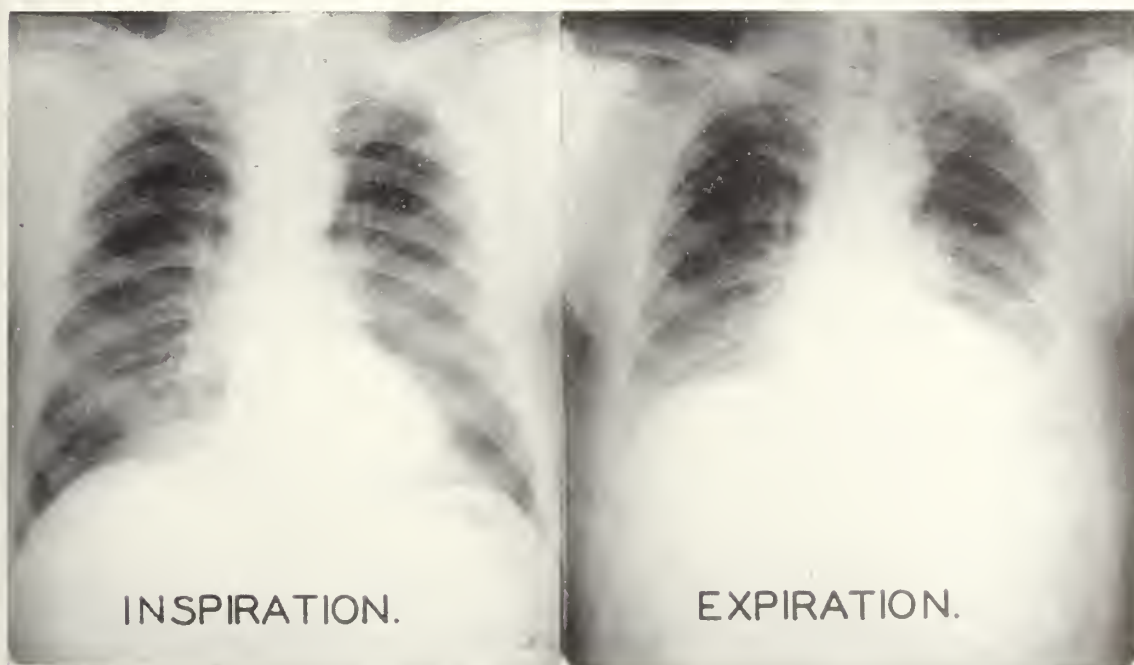


Fig. 5. A difficult case to evaluate clinically. A 58-year-old anthracite miner with a history of 15 years' inside exposure and 20 years' outside. Still working outside. Complains of slight dyspnea on exertion, present one year. Marked cough and expectoration. Frequent disabling chest colds. Function measurements: maximal breathing capacity normal, vital capacity 71 per cent of normal predicted and residual air 2375 cc. representing 44.7 per cent of total lung volume, producing a moderate to advanced degree of pulmonary emphysema. Arterial oxygen saturation 93.0 per cent at rest and 93.6 per cent immediately after step-up exercise. Oxygen removal from inspired air 2.37 per cent at rest and 4.28 per cent during exercise. Moderate degree of pulmonary function impairment present. In this case the increased residual air is the most abnormal factor. Note the improvement in lung ventilation efficiency during exercise. The disabling chest colds correlate with the increased residual air.

Millikan oximeter which gives arterial oxygen saturation values comparable to the Van Slyke determination of oxygen content and capacity.¹³ This type of oximeter will be used to measure arterial oxygen saturation in anthracosilicotic cases at rest and during exercise, including a steady state of exercise on a treadmill.

Oxygen Uptake from Inspired Air

The amount of oxygen removed from a given volume of air breathed is a measure of the lung ventilation efficiency. For example, if the amount of oxygen removed from the air breathed is 4.5 per cent and the amount of carbon dioxide added 3.6 per cent, then 45 cc. of oxygen is removed from and 36 cc. of carbon dioxide is added to each liter of air breathed. Instead of expressing

this measurement as a per cent, the values may be designated as respiratory equivalents, the number of liters of air required to supply 100 cc. of oxygen uptake per minute. There was no evidence that the carbon dioxide values of the expired air were of greater significance than the oxygen values either at rest or during exercises in anthracosilicotic patients.³ If the amount of oxygen removed from the air was markedly reduced, the volume of inspired air required would be proportionately increased for a given amount of work and oxygen consumption; and if the ventilation volumes (MBC and vital capacity) were reduced, the individual would be unable to meet the elevated oxygen requirement.

No correlation was found between the degree of emphysema and the per cent of oxygen re-

TABLE III

COMPARISON OF OXYGEN AND CARBON DIOXIDE IN REBREATHED AIR¹⁴ WITH OTHER PULMONARY FUNCTION MEASUREMENTS

	<i>Group 1</i> (24 Cases)		<i>Group 2</i> (26 Cases)	
	<i>Average</i>	<i>Range</i>	<i>Average</i>	<i>Range</i>
Oxygen per cent in rebreathed air	8.57	6.74-9.93	11.21	10.07-14.24
Carbon dioxide per cent in rebreathed air	8.02	6.00-9.54	6.86	5.14-7.69
Vital capacity				
(a) Observed (cc.)	3190	1460-5220	3165	1886-5300
(b) Per cent of normal predicted value	76.4	35.9-100	76.2	46.3-100
Maximal breathing capacity				
(a) Observed, liters per min.	72	27-147	68	21-153
(b) Per cent of normal predicted value	63.0	26.7-100	67.2	24.8-100
Ventilation, liters per min., per sq.m., B.S.A.				
(a) Rest	4.5	3.3-5.3	5.0	3.0-6.7
(b) Exercise	11.4	7.2-14.4	12.6	8.8-18.4
Breathing reserve at rest per cent of MBC	87	78-98	85	63-96
Residual air (cc.)	1775	720-3665	1790	813-3041
Residual air per cent of total lung volume	36.1	10.0-58.4	35.8	16.9-54.3
Oxygen consumption cc. per sq.m., B.S.A.				
(a) Rest	147	124-166	145	128-184
(b) Exercise	524	240-972	480	306-828
Arterial blood resting				
(a) pCO ₂ , mm.Hg.	45	31-59	44	25-62
(b) pO ₂ , mm.Hg.	75	55-88	81	59-108
Hemoglobin, per cent saturation				
(a) Rest	93.3	87.0-96.5	94.1	81.5-97.5
(b) Exercise	92.5	85.0-98.0	90.9	79.6-97.8
Resting oxygen gradients mm.Hg.				
(a) Aeration	55	33-73	53	23-69
(b) Transfer	20	4-40	17	6-48
Resting tidal air, per cent effective	60	53-68	56	48-72

moved in anthracosilicosis cases.³ In most instances the per cent of oxygen removed from the air breathed was below the normal value both at rest and during exercise. Since the lung ventilation efficiency was reduced in most anthracosilicotic patients, even in the group with no pulmonary emphysema, the per cent of oxygen removed was of limited value as a single measurement in evaluating disability. If the oxygen uptake decreased markedly with exercise, these measurements became significant for the individual case, but provided slight information as to the nature of the functional impairment other than indicating the existence of a disproportion between ventilation and perfusion. The oxygen uptake and carbon dioxide output determinations were useful when evaluated with other tests, but these measurements should not be used alone.

A rebreathing test designed to evaluate the capability of the lungs to diffuse oxygen and carbon dioxide has been described by Ornstein and his co-workers.¹⁴ This test consists of letting the patient rebreathe 1 liter of air for 20 seconds after one minute of exercise (30 step-ups on a stool 8 inches high). According to Ornstein if the oxygen content in the rebreathed air is greater than 10 per cent, diffusion in the lungs is impaired. This test was performed as a supplementary test for correlation with other pulmonary function studies in 50 consecutive unselected coal miners. These data are presented in Table III. In 24 of the cases the oxygen content was less than 10 per cent and in 26 cases the oxygen was greater than 10 per cent in the rebreathed air. No apparent correlation could be found between the per cent of oxygen in the rebreathed air, vital capacity, maximal breathing capacity, minute ventilation, breathing reserve, degree of emphysema, arterial $p\text{CO}_2$, arterial $p\text{O}_2$, arterial oxygen saturation, resting oxygen gradients, or the per cent tidal air effective. There was no correlation of the arterial $p\text{O}_2$ and $p\text{CO}_2$ with the per cent of oxygen in the rebreathed air when the individual cases were correlated.

The Ornstein test for evaluating oxygen diffusion in the lung obviously is not applicable in anthracosilicosis. Furthermore, in anthracosilicosis the basic defect in oxygen transfer is a distribution difficulty (unequal alveolar aeration and perfusion) rather than a diffusion difficulty in the pulmonary membrane.¹¹ Wright¹⁵ has also questioned the value of Ornstein's test in evaluating the degree of impairment in pulmonary dis-

ease. Studies in other types of chronic pulmonary disease indicate that the distribution factor is the one of primary importance.^{16, 17, 18} The wide individual variations encountered in ventilation, residual air, oxygen uptake from the air breathed, and the arterial blood values, both during rest and exercise, preclude the use of any one test for the satisfactory integration and appraisal of disability in all types of cases. For an example of a difficult case to evaluate clinically see Fig. 5.

Pulmonary Circulation

The four main groups of measurements of pulmonary function described are usually sufficient to permit an accurate evaluation of the pulmonary impairment present, but a fifth factor (the pulmonary circulation) may be the major one in producing disability in some instances. The effect of acute hypoxia and the abnormal response to exercise by the pulmonary circulation in chronic pulmonary disease have already been discussed. When measurements on ventilation, residual air per cent of total lung volume, and the respiratory gas exchange revealed slight to moderate involvement, a prolongation of dyspnea for 3 to 5 minutes following the one-minute step-up exercise test suggests that the pulmonary circulation is the major factor producing disability (increased pulmonary artery pressure and pulmonary vascular resistance). At the present time studies are being extended to investigate the cardiac and pulmonary circulation factor in anthracosilicosis, including measurements of pulmonary artery pressure and cardiac output with calculation of the pulmonary vascular resistance.

Discussion

Pulmonary function was evaluated clinically with respect to the patient's ability to supply oxygen to and remove carbon dioxide from the tissues both at rest and during exercise breathing air. When adequate gas exchange was provided both at rest and during exercise, pulmonary function was considered normal.

The physiologic tests necessary to evaluate pulmonary function have been presented in five major groups, namely: (1) lung and ventilation volumes (maximal breathing capacity, vital capacity, and minute ventilation rate (liters per minute) at rest and during exercise), (2) degree of pulmonary emphysema (residual air expressed quantitatively as per cent of total lung volume),

(3) arterial blood oxygen saturation at rest and during exercise, (4) oxygen uptake from inspired air (the amount of oxygen removed from a given volume of air breathed), and (5) pulmonary hemodynamics (increased pulmonary artery pressure and pulmonary vascular resistance particularly during exercise).

Vital capacity and maximal breathing capacity are of limited value in appraising the disability in patients with little or no pulmonary emphysema. Maximal breathing capacity measurements are a more reliable indication of the degree of disability than are the deviations in vital capacity, which as a single measurement was of only slight value. There was no correlation of the resting or exercise minute ventilation volumes with the degree of pulmonary function impairment. The duration of dyspnea after the step-up exercise test was quite variable, and in general this measurement correlated poorly with the other findings, unless abnormally prolonged (3 to 5 minutes). Pulse and respiration rates during exercise were of little value and showed no correlation with the over-all physiologic evaluation of impairment.

The degree of pulmonary emphysema was a very significant measurement. The quantitative classification of emphysema has proved satisfactory for grouping the cases for study and analysis and for the evaluation of disability as shown by the close correlation with the other physiologic measurements.⁶ An increased volume of residual air constitutes a potential hazard in the presence of upper respiratory infections and bronchospasm, because both conditions limit the amount of hyperventilation possible without dyspnea. Some patients with large amounts of residual air do fairly well as long as the vital capacity remains high and compensatory hyperventilation without dyspnea is adequate to compensate for mild to moderate exercise.

The per cent of oxygen uptake from the air breathed (lung ventilation efficiency) has a limited significance in the evaluation of disability. If the per cent of oxygen removed from the inspired air was decreased with exercise, this measurement was significant for the particular case but provided little information as to the nature or degree of the impairment other than to indicate the existence of a disproportion pertaining to both the intrapulmonary mixing of inspired air and the pulmonary blood flow. Oxygen uptake determinations are useful for the

evaluation of disability when applied with other tests, but these measurements should not be used alone. The Ornstein air rebreathing test designed to estimate the capability of the lungs to diffuse oxygen was of no value in anthracosilicotic patients. Extensive studies have shown that the major defect in the transfer of oxygen in the lungs to the blood is one of distribution (unequal alveolar aeration and perfusion), and not a diffusion difficulty with increased resistance in the pulmonary membrane.

The arterial blood oxygen saturation at rest and during exercise was a very important measurement. A single resting arterial oxygen saturation measurement has but limited value unless extremely low, because of the wide individual variations accompanied by only small average changes when correlated with the degree of pulmonary emphysema and disability. However, when the exercise arterial oxygen saturation was compared with the resting value, significant information was provided—a marked drop during exercise indicating severe impairment. An individual with a resting arterial oxygen saturation of 90 per cent or even less may be able to do a moderate amount of work if during exercise there is a slight increase in the saturation, a situation which occurs fairly frequently. There is no apparent means of predicting the effect of exercise on the arterial oxygen saturation. In general, the more marked the pulmonary emphysema, the greater is the decrease in arterial oxygen saturation with exercise, but this was not true in all cases, for the arterial oxygen saturation was increased after exercise even in the presence of extensive emphysema in some cases, and it was decreased in others with no emphysema. The entire respiratory gas exchange was definitely improved in some cases during mild to moderate exercise.

Roentgenologic changes are poorly correlated with pulmonary function changes, including the degree of emphysema in coal miners. There was no characteristic feature of the chest roentgenogram to differentiate an anthracite from a bituminous miner. The studies on pulmonary function in anthracosilicosis revealed similar physiologic disturbances in both bituminous and anthracite miners. Individual cases exhibited marked variations in the degree of involvement for the various factors which have been presented. However, the individual case cannot be classified from the function studies, for there is

no typical pattern which separates the bituminous from the anthracite miner, and even the clinical symptoms are similar.¹⁹

Conclusions

1. The significance of various types of physiologic measurements in the evaluation of pulmonary function impairment in anthracosilicosis is discussed.

2. No characteristic pattern was observed in the physiologic test measurements which would distinguish anthracosilicosis occurring in the anthracite and bituminous miners. In both groups individual cases exhibited marked variations in the degree of involvement of the various factors.

3. No single physiologic test was adequate in evaluating pulmonary function impairment in anthracosilicosis, and the chest roentgenogram was poorly correlated with the functional changes in many cases.

4. Physiologic tests of pulmonary function provide valuable information to supplement the usual clinical and roentgenologic examination for the appraisal of disability.

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DON'T BORROW ON YOUR SAVINGS

Risking the Future to Enjoy the Present

. . . It is exceedingly hard for men and women grown suddenly accustomed to excessively high wages further boosted by overtime pay to adjust themselves when they realize that the spree is over and that something akin to normalcy is returning. Hundreds of thousands of families—yes, even millions—have been living in a fancy style to which they never aspired before the war. They like it very much and can't be blamed for that. But as in all pipe dreams there must come an awakening.

Countless numbers of families have indulged in luxuries that are ordinarily entirely out of their reach. Many have purchased automobiles in a price range obviously beyond their means. They want every electrical appliance on the market. They want furs, jewelry, and dozens of other luxuries. They want fancy vacations in Florida or California. The business of keeping up with the Joneses has become a national disease. . . .

This is, we hope, a word of warning to any who may be toying with the idea of risking everything for a few more weeks or months of high living. . . . —*Roanoke (Va.) World News*.

ANESTHESIA FOR OUTPATIENTS

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ANESTHESIA for surgical outpatients is today more in demand than at any other time in medical history. Many more minor surgical procedures are referred to the general surgeon. Since his practice is limited almost entirely to the confines of a hospital, the anesthesiologist is called upon to manage and administer the anesthetics for his patients. In doing so the anesthesiologist has gained the experience of anesthetizing patients, with both local and general anesthesia, who in most instances have not been prepared for anesthesia as have hospital patients. The knowledge gained in anesthesia of these outpatients can be of utmost value to the general practitioner who is, or contemplates, doing minor surgery in his office or in the hospital.

Local Anesthesia

Probably the safest form of anesthesia that can be used for minor surgical procedures is that produced by one of the local anesthetic agents, such as procaine and metycaine. Procaine is the agent of choice because of its low toxic properties, and the duration of anesthesia produced is most suitable to the time required for most minor surgical procedures.

The concentration of procaine for local infiltration and field blocks should not exceed 0.5 to 2.0 per cent solution. This solution should always be freshly prepared for each case from stock ampules containing 5 per cent procaine. This will eliminate the possibility of injecting the wrong solution, which may cause sloughing in the area injected or a marked toxic reaction in the patient. Three drops of a 1-1000 solution of epinephrine to each ounce of the procaine solution will be sufficient to produce local vasoconstriction, prolong the action of procaine by delaying absorption, and minimize the systemic response to epinephrine.

The injection of a local anesthetic agent is not without the possibility of producing toxic manifestations in the patient through sensitivity to the drug, too rapid absorption, or accidental intravascular injection. The knowledge of the toxic manifestations of local anesthetic drugs and the treatment of such will enable the physician to recognize toxicity early and institute prompt treatment.

Symptoms and Signs of Procaine Toxicity

Two types of systemic toxic effects may be seen with procaine. The most frequent type is that of central nervous system irritation. The patient becomes apprehensive, nervous, uncooperative, and this is rapidly followed by muscular twitching, which becomes progressively worse until generalized convulsions develop. These may later progress to marked depression and death. The presence of bradycardia early will distinguish this reaction from that of epinephrine.

In many instances the intravenous administration of one of the rapidly acting soluble barbiturates, such as pentothal sodium, will immediately control the central nervous system irritability. Small amounts of pentothal sodium should be administered at a time, such as 2 cubic centimeters of a 2 per cent solution. Subsequent injections of pentothal sodium are given as necessary. Other barbiturates may be administered intravenously in corresponding dosage, such as nembutal, sodium amytal, etc. Their action is much slower in onset and the duration longer. Oxygen and a satisfactory apparatus for its administration should always be on hand and should be administered if respiratory depression or cyanosis is present.

The second, and fortunately the least common, toxic manifestation is the syncopal type. It is usually manifest by loss of consciousness and circulatory collapse—an anaphylactic type of reaction. Immediate intravenous injection of 2 to 3

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minims of a 1-1000 epinephrine solution is used to combat the circulatory shock, and oxygen inhalations are given for depressed respirations and to combat the stagnant anoxia produced by the circulatory collapse.

The barbiturates have long been known to be antagonistic to the toxic effect of the local anesthetic agents. The preoperative administration of nembutal or seconal may help to prevent or minimize a toxic reaction.

Field Block

In performing a field block, the anesthetic agent is injected into the skin and subcutaneous tissues in a diamond-shaped zone around the lesion.

Field block is much to be preferred over local infiltration for the removal of superficial papillomas, lipomas, sebaceous cysts, and other benign superficial lesions.

Fractures can be reduced by the injection of 15 cubic centimeters of a 1 per cent solution of procaine directly into the fracture hematoma. If the fracture is older and the hematoma is undergoing beginning organization, injection of the local anesthetic agent above and below and both anterior and posterior to the site of fracture will produce the same desired results.

Anesthesia for minor surgical procedures of the fingers and hand is best produced by metacarpal block, and operative procedures of the toes and foot with metatarsal block.

For circumcision, block anesthesia may be produced by subcutaneous infiltration encircling the base of the penis and the infiltration of the dorsal sensory nerves beneath Buck's fascia.

The Child Outpatient

Most children below the age of 12 years have not developed enough mentally to tolerate or cooperate while surgical procedures are done with local or conduction anesthesia. It is, therefore, almost imperative that these procedures be done with general anesthesia. This can take place without event, providing the general physical condition of the child is evaluated in the same light as if it were to be anesthetized for a major surgical procedure and prepared likewise. Smallness of the operative procedure is not synonymous with smallness of the anesthetic procedure.

If a child has been injured shortly after taking food, the emptying time of the stomach will

be markedly delayed. General anesthesia produced with the commonly used agents is apt to produce vomiting with a good chance for bronchial aspiration. If this child is taken into the second stage of anesthesia slowly, vomiting will be almost inevitable, and while vomiting, laryngeal and cough reflexes are still intact. This method of emptying the stomach is much more efficient than any form of gastric lavage. When the stomach is emptied, anesthesia may be continued to the desired level.

The operator should never attempt to administer the anesthetic agent and also perform the operative procedure unless the operative procedure is extremely short in duration, such as myringotomy or an incision and drainage of a small abscess.

General Anesthesia for the Adult

The preanesthetic evaluation of the patient's general physical status and preparation for anesthesia should be the same for the outpatient as it is for the inpatient. Facts about the competency of both the cardiovascular and respiratory systems can be rapidly ascertained by direct questions. A physical examination of the heart and lungs should be as thorough as that done on the inpatient. In order to save time, preanesthetic medication can be given by the intravenous route.

The use of pentothal sodium should always be preceded by the administration of atropine sulfate, either hypodermically or intravenously, regardless of how short the operative procedure to be done.

Operations about the head and neck, and especially those in or about the respiratory passages, are hazardous unless they are done with an endotracheal tube in place. This allows for complete control of the patient's airway. The endotracheal tube may be inserted with the use of topical anesthesia while the patient is still awake or after induction of anesthesia and topical cocaineization of the larynx. This facilitates intubation during light anesthesia, and since most outpatient surgical procedures require little or no relaxation, it is not necessary to take the patient down to the third plane of the third stage of anesthesia in order to accomplish intubation.

It is unwise to administer a general anesthetic to any surgical outpatient unless accompanied by a responsible person to see that the patient returns home safely. This is especially important

if pentothal sodium has been used as an anesthetic agent, because of the likelihood of the development of a period of amnesia that can last for hours.

Summary

The anesthetic management of the surgical outpatient should be as exacting and as carefully carried out as if he were an inpatient.

The toxicity of local anesthetic drugs and the

treatment of such has been discussed along with several common local anesthetic procedures.

General anesthesia for both children and adults has been discussed from the standpoint of evaluation of the anesthetic risk and management of the anesthesia period.

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PHILADELPHIA COUNTY TO HOLD SEMINAR ON CLINICAL PATHOLOGY

On Thursday, March 9, the Section on Clinical Pathology will hold its eighth annual seminar at the Philadelphia County Medical Society, 21st and Spruce Streets. Among the subjects to be covered are: "Huggins' Test for Cancer," "Studies in Human Fertility," "Microchemical Methods," "Ocular Pathology," "Tumors of the Oral Cavity," and "Experimental Hepatitis." The registration period will begin at 9 a.m., and the first presentation will follow at 10 a.m. There will be three papers in the morning lasting one hour each and three papers in the afternoon. Outstanding speakers are being selected to cover the above subjects, as well as outstanding discussers. There will be no registration fee and all physicians are invited to attend. The chairman of the section is Andrew J. Donnelly, M.D., and inquiries should be addressed to him at 301 South 21st St., Philadelphia 3.

SCRUTINY OF INCOME TAX RETURNS

Business analysts have recently reviewed for their customers the reasons underlying the federal government's increased interest in individual income tax returns. Their findings might be of benefit to the medical profession.

This year the Bureau of Internal Revenue will have employed 27,000 agents. This will result in closer scrutiny of income tax returns than at any other time. A few years ago, with less than half the present number of agents, the government collected almost 400 million dollars in extra revenue. This year they expect to collect more than two billion dollars in taxes in instances where individuals attempted to avoid paying or where errors had been made in the returns.

It has long been known by the government that errors or dishonesty in making returns occur most frequently among self-employed individuals such as doctors, lawyers, farmers, etc. Their bookkeeping is less efficient than methods employed by business firms, and most of

their transactions are cash. These groups have been rather carefully checked for some years and this process will continue with even greater vigor in the future. It is readily understandable when it is noted that more than 50 per cent of all evasion was detected in returns showing incomes of \$7,000 or more.

Closer scrutiny of incomes falling between \$5,000 and \$7,000 will be noted. Until now these have been spot-checked, but with some two million returns falling into this range the government plans detailed auditing of a much higher percentage in the future. Study of returns listing less than \$5,000 will probably not be undertaken extensively until 1952 or later.

Many persons will be asked to produce records supporting their claims. In the next year or two the professional man who is not investigated may well be the exception rather than the rule. The report also suggests that returns for the taxable year 1945 and earlier are relatively safe, except in those instances where the government has reason to believe that fraud was attempted. Primary attention will be given the years 1946 and 1947, particularly to the physicians' group, because their incomes increased sharply during the war years.

To be safe a physician should keep careful records of all transactions. His books should not be discarded for at least five years. Much grief might be spared if a competent tax expert would be employed to assist the physician in making out his returns. This could incidentally save the taxpayer considerable sums of money in interest and penalties.

As an employer the physician also has certain responsibilities. Withholding taxes on the salaries of employees are required to be deposited monthly, and only one in three employers abides by these regulations at present.

The Bureau's goal is to verify every return they get, at least as to mathematics. There are some 53 million returns and of course it will be a physical impossibility to make a detailed analysis of each of these, but with added personnel and much new accounting equipment the government will make a closer scrutiny of more returns this year than ever before.—*Journal of the Kansas Medical Society*.

Clinical Use of the Newer Antibiotics

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AMONG the newer antibiotics which have been developed, there has been considerable experience with four, namely, aureomycin, chloromycetin, bacitracin, and polymyxin. Aureomycin and chloromycetin are unusual because they are effective and rapidly absorbed when administered orally and because they are apparently effective in the treatment of some infections caused by certain viruses and rickettsiae. Thus these two antibiotics in particular widen considerably the scope of antibiotic therapy and, because they are easily administered, reduce the amount of work associated with the care of the patient.

Aureomycin

Aureomycin, an antibiotic, produced by *Streptomyces aureofaciens*, is effective against a great many gram-positive and gram-negative bacteria, viruses of the psittacosis-lymphogranuloma group, and certain rickettsiae.¹

Aureomycin is provided in three forms. Aureomycin hydrochloride forms the basis of the three preparations. For oral use, the hydrochloride salt is available in 250 mg. capsules. Aureomycin hydrochloride is also available for intravenous use. The 10 cc. of 2.6 per cent solution of (-) leucine is added to the ampule containing 100 mg. of aureomycin. The proper dose of this freshly mixed solution is then injected intravenously over a period of at least 5 minutes. Aureomycin hydrochloride is very acid (pH 2.9) and no satisfactory preparation for intramuscular use is available at the present time.

For ophthalmic use the 25 mg. of aureomycin hydrochloride with sodium chloride and sodium borate provided in a vial is simply diluted with 5 cc. of distilled water.

Dosage.—The usual oral dose of aureomycin is 25 mg. per kilogram of body weight per day in divided doses. For severely ill patients as much as 50 mg. per kilogram has been used. The usual oral dose for adults, therefore, is 500 mg. or 0.5 gram every six hours, giving a total daily dose of 2 grams per day.

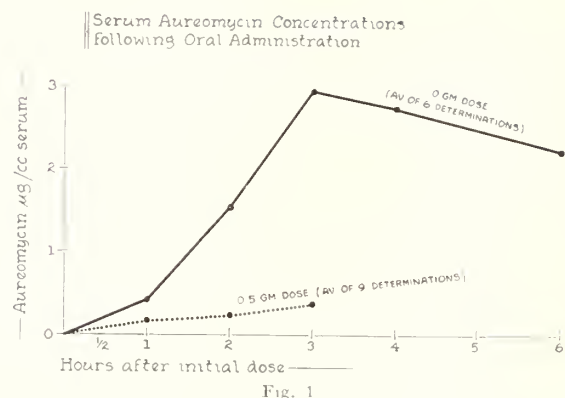
Exception to this general rule of dosage is made in the treatment of undulant fever or brucellosis. Because of the possibility of a Herxheimer reaction, a total dose of 250 to 500 mg. is administered in four divided doses for the first three or four days. The daily dose is then increased to a total daily dose of 4 to 6 grams per day.

Patients who cannot be given oral medication should receive the intravenous preparation on the basis of 5 mg. of aureomycin per kilogram of body weight per day in divided doses. The intravenous dose is therefore approximately one-fifth of the oral dose.

Toxicity.—Approximately 50 per cent of the 120 patients who have received aureomycin in our experience have had slight to severe evidences of gastro-intestinal irritation. With the use of the improved material available at the present time, the incidence of gastro-intestinal irritation has been considerably lower. These symptoms vary from a slight decrease in appetite or a "creeping feeling" in the abdomen to nausea, vomiting, and diarrhea. In the patients with the more severe symptoms, aureomycin therapy could not be continued. Usually there is an increase in the bulk of the stools and not infrequently an increase in the number of stools per day. Soreness and redness of the mouth and tongue have developed in four patients. Because of the similar appearance of these lesions to those observed in deficiencies of certain vitamins of the B complex, we have empirically advised the use of vitamin supplements with aureomycin therapy. In occasional patients, pruritus and develops. Other than symptoms referable to the

¹Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.

From the Harrison Department of Surgical Research, Schools of Medicine, University of Pennsylvania, and the Surgical Times of the Hospital of the University of Pennsylvania, Philadelphia



gastro-intestinal tract, no further toxic effects have been noted following aureomycin therapy. Studies of renal function, hepatic function, various blood chemical determinations, and blood cytology have failed to reveal any serious toxicity which resulted from aureomycin therapy.¹⁵ Considerable difficulty has been encountered by those studying aureomycin in obtaining reproducible results in determining aureomycin concentrations in body fluids.

Absorption.—Following an initial dose of 0.5 Gm. of aureomycin orally in 9 patients, the concentration of aureomycin in the blood serum gradually rose in three hours to a level of approximately 0.4 ug. of aureomycin per cc. of serum (Fig. 1). Following a 1 Gm. dose in 6 patients, the concentration was approximately 3 ug. of aureomycin per cc. of serum at three hours. After continuous therapy at the rate of 2 grams per day, concentrations as high as 5 or 6 ug. per cc. of serum have been obtained. Following intravenous administration, peak levels of 6 to 10 ug. of aureomycin per cc. of serum can be obtained for a very short period of time after injection. Concentrations as high as 205 ug. of aureomycin have been obtained in the urine. The antibiotic may produce a yellow-green color of the urine.

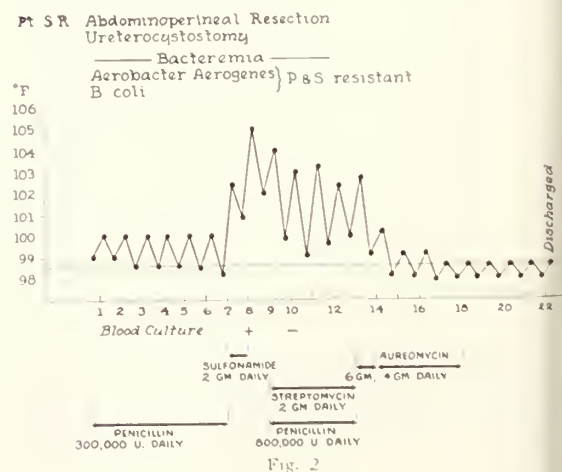
Distribution.—In a child which weighed 25 pounds and which had meningitis and a cerebellar abscess, a massive total daily dose of 2 grams produced concentrations of from 0.5 to 2.0 ug. of aureomycin in the cerebrospinal fluid. Brainerd² has reported that aureomycin appears in the bile, and in pleural, gastric, and joint fluids as well as the cerebrospinal fluid.

Clinical Results.—Good results following aureomycin therapy have been obtained in patients with Rocky Mountain spotted fever, var-

ious types of typhus fever, primary atypical pneumonia, brucellosis or undulant fever, dermatologic and ophthalmologic infections, urinary tract infections, lymphogranuloma inguinale, and other infections. There has been no extensive experience in the treatment of any given infectious disease. The largest number of reported patients with any given disease treated with aureomycin is the 75 total cases of primary atypical non-bacterial pneumonia—Meiklejohn,³ Kneeland,⁴ Schoenbach,⁵ and Finland.⁶

Primary Atypical Pneumonia.—In the reported patients with primary atypical non-bacterial pneumonia, the symptoms have subsided within 24 hours and the fever has disappeared in from 12 to 72 hours.^{3 to 6} Three of the 22 patients of Meiklejohn had relapses after therapy was discontinued.

Rocky Mountain Spotted Fever.—A number of patients with Rocky Mountain spotted fever treated with aureomycin have been reported.^{7 to 10} This disease caused by the *Rickettsia rickettsii* usually has a mortality of 15 per cent with a mortality of 37.5 per cent in the Bitter Root Valley. In these patients, their symptoms were improved in 24 hours, their temperatures were normal, and the rash faded 72 hours after aureomycin therapy was begun. Aureomycin appears to be less toxic and probably more effective than para-aminobenzoic acid in the treatment of this disease. Since the intelligent use of para-aminobenzoic acid requires careful supervision with the aid of frequently repeated white blood cell counts, serum carbon dioxide combining power, non-protein nitrogen, and serum para-aminobenzoic acid concentrations to avoid leukopenia and possible liver and kidney damage, treatment with



aureomycin is less difficult than with para-amino-benzoic acid.

Brucellosis.—In the treatment of brucellosis or undulant fever, aureomycin is thought to be distinctly superior to combined streptomycin-sulfadiazine therapy. A total of 31 patients have been reported by Spink,¹¹ Bryer,¹² Ross,¹³ and Woodward.¹⁴ These patients had an immediate response to aureomycin; however, there were three recurrences in the 24 patients reported by Spink. Slightly better results in the treatment of brucellosis have been obtained with chloromycetin therapy as reported by Woodward.¹⁴ Spink¹¹ now recommends a larger dose of aureomycin for a longer period of time, namely, 4 to 6 grams for 14 days. It must be remembered that a Herxheimer reaction with nausea, vomiting, diarrhea, and lesions of the skin and mucous membranes may occur after the initiation of aureomycin therapy. Treatment should be initiated with a total daily dose of 250 to 500 mg. daily for three to four days and then gradually increased to 4 to 6 grams per day.

Lymphogranuloma Inguinale.—Encouraging experiences with the use of aureomycin in the treatment of lymphogranuloma inguinale have been reported by Wright.¹⁵ In their experience

and 3 patients in our experience the bubos of the acute phase of the disease decrease in size in the remarkably short time of four days. The 20 mg. daily dose used in some instances by Wright¹⁵ might be considered inadequate. Fletcher and Sigel of the University of Pennsylvania have treated 14 patients with chronic lymphogranuloma inguinale with aureomycin. A few of these patients have been treated several times. They have used a total daily dose ranging from 20 mg. to 2 grams per day. Dr. Sigel has failed to find a significant drop in the serum titer for lymphogranuloma inguinale in these patients even after one month's treatment with 2 grams per day.

Urinary Tract Infections.—Good results were obtained by Collius¹⁶ in the treatment of urinary tract infections with aureomycin. The symptom and pyuria were abolished completely or temporarily in all but one of his more recent patients. It is to be expected that those patients who require frequent instrumentation or those with other associated genito-urinary tract pathology will have a recurrence of their infection. Infections due to the proteus and pyocyanus do not respond to aureomycin therapy. It is interesting to note that these organisms are also highly resistant to chloromycetin in vitro.

Chloromycetin Serum Levels
Following Initial 0.5 gm. Oral Dose.

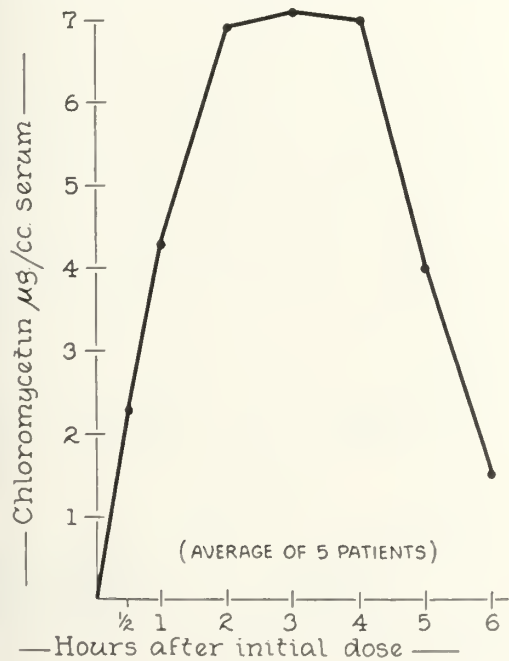


Fig. 3

Miscellaneous Infections.—Wright¹⁷ has treated 49 patients with peritonitis secondary to perforated peptic ulcer or appendicitis with good results. Yeager¹⁸ has reported that aureomycin is effective in the treatment of experimental peritonitis in dogs. Four of 6 patients with staphylococcal bacteremia resistant to penicillin have survived following aureomycin therapy according to Nichols.¹⁹ In our experience one patient with *Aerobacter aerogenes* bacteremia responded well to aureomycin therapy (Fig. 2). In a few patients with shingles or herpes zoster, the pain has been relieved within 12 hours and the lesions have failed to progress.²⁰ Apparently relapses do occur if aureomycin therapy is stopped too early.

Braley and Sanders²¹ have reported that 303 of 401 patients with ocular infections have responded to local or local and systemic treatment with aureomycin. The ocular infections treated included staphylococcal, pneumococcal, and influenza conjunctivitis and infections due to the Morax-Axenfeld bacillus and Friedländer's bacillus. Finland¹ has reported that aureomycin was quite effective in the treatment of 66 patients

with gonorrheal urethritis. Experiences of various investigators indicate that aureomycin might be useful in the treatment of amebiasis,²² pemphigus, meningitis due to *Hemophilus influenzae*, tularemia,²³ and pneumonia due to pneumococci, streptococci, and staphylococci. The various types of typhus including typhus fever, Brill's disease, and murine typhus have responded favorably to aureomycin therapy in a few patients.¹⁴ Irgang²⁴ and O'Leary²⁵ have observed beneficial effects of oral aureomycin in the treatment of primary syphilis. It has also been tried for the pulmonary complications of pancreatic fibrosis²⁵ with clinical improvement.

Preliminary reports regarding the usefulness of aureomycin in the treatment of typhoid fever were somewhat encouraging¹; however, only about one-half in one group of 45 cases were definitely improved. In our experience with four patients with typhoid fever, aureomycin had no demonstrable effect.

Chloromycetin

Chloromycetin or chloramphenicol, an antibiotic produced by *Streptomyces venezuelae*, can also be prepared synthetically. The present commercial preparation is a mixture of synthetic and biologic antibiotic. It is a neutral pure crystalline substance which is quite stable. There are no known toxic effects in man following its oral administration. There is no preparation available for parenteral use at the present time.

Dosage.—The total daily oral dose varies from 2 to 6 grams, in divided doses every 2 to 4 hours. For most infections an initial dose of 60 mg. per kilogram of body weight is administered. This initial dose is followed by $\frac{1}{4}$ Gm. (250 mg.) every three hours until the temperature has been normal for at least 48 hours. Thus the average adult would receive 6 grams in the first 24 hours and 2 grams total daily dose thereafter. For typhoid fever following the initial 60 mg./kg. dose, $\frac{1}{4}$ Gm. every two hours or 3 grams is administered per day until the temperature has been normal for at least eight days and preferably for two weeks.²⁴ For urinary tract infections an interval of 4 to 6 hours with a total daily dose of between 2 and 3 grams seems satisfactory.

Blood Serum Levels.—Following oral administration chloromycetin, like aureomycin, is readily absorbed from the gastro-intestinal tract. In 5 patients who received an initial oral dose of

0.5 Gm. of chloromycetin a concentration of approximately 7 ug. per cc. of serum was obtained in 2 to 4 hours after administration (Fig. 3). We have observed 451 mg. of chloromycetin per cc. of urine in a patient who had received 2 grams of chloromycetin per day for five days.

Clinical Results of Chloromycetin Therapy.—Good results have been obtained with chloromycetin in the treatment of Rocky Mountain spotted fever, typhus fever, scrub typhus, typhoid fever, brucellosis, bacillary urinary tract infections, and in a few patients with primary atypical non-bacterial pneumonia and tularemia.

Rocky Mountain Spotted Fever.—Pincoffs, Guy, Lister, Woodward, and Smadel²⁷ have reported their experiences in the treatment of Rocky Mountain spotted fever. In 15 patients the symptoms were improved within 48 hours and the temperature in all cases was normal within 76 hours of the initiation of treatment. The duration of the disease of the chloromycetin-treated patients was 9.5 days as compared with 16 days for a representative control group. Pincoffs discontinued therapy after 48 hours of normal temperature. It is now recommended that therapy be continued for 48 hours after the temperature has become normal.

Typhoid Fever.—Chloromycetin has been very effective in the treatment of patients with typhoid fever. Smadel and Woodward²⁶ have reported 44 patients with typhoid fever who have been treated with chloromycetin. In one group of these patients the symptoms were improved in 3.5 days and their temperatures were normal in 4.5 days. Smadel and Woodward believe that, in the treatment of typhoid fever, chloromycetin should be continued for more than 8 but not more than 14 days. Four of the one group of 21 patients continued to have stools positive for *E. typhosa* after therapy was discontinued.

MC Typhoid Fever Diabetes

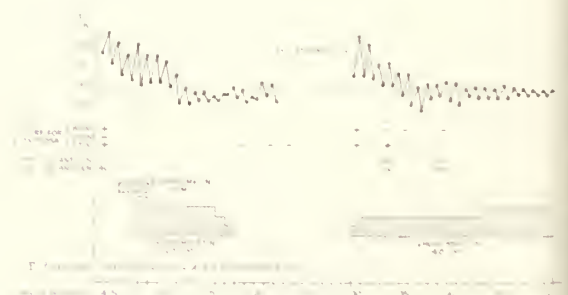


Fig. 4

Symptoms may recur following inadequate therapy; however, these symptoms promptly disappear with further chloromycetin therapy (Fig. 4). It does not appear as though chloromycetin would eliminate *E. typhosa* from the gastrointestinal tract of typhoid carriers.

Primary Atypical Non-bacterial Pneumonia.

—The successful use of chloromycetin in a few patients with primary atypical pneumonia suggests that this antibiotic may be useful in the treatment of this disease. In the patients treated the temperature became normal in 36 to 48 hours. The antibiotic should probably be continued for 3 to 5 days after the temperature has become normal in order to prevent relapses. Chloromycetin has also been effective in the treatment of several types of typhus infection.

Bacitracin

Bacitracin has been demonstrated to be an effective antibiotic agent for the treatment of many surgical, dermatologic, and ophthalmologic infections.^{28, 29, 30} However, since Michie, Zintel, Ma, Ravdin, and Ragni³¹ have demonstrated moderate to severe reduction of renal plasma flow, tubular excretion, tubular reabsorption of phosphate, and glomerular filtration rate, we have discontinued the use of systemic bacitracin. Our studies have been confirmed by Miller.³² There is no evidence that bacitracin is toxic when used topically or locally.

Polymyxin or Aerosporin B

Polymyxin or aerosporin is a very effective antibiotic agent as judged by *in vitro* tests. On a weight for weight basis it is much more effective than chloromycetin and aureomycin against a great many gram-negative bacteria. We found it effective in the treatment of patients with bacillary urinary tract infections. In our experience it was not effective in the treatment of four patients with typhoid fever. The incidence of peripheral nerve disturbances and kidney damage, however, was very high and therefore this antibiotic is not now available for clinical use.

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Some Aspects of the Relation of Cholesterol to Vascular Disease

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RECENT recognition of the increasing importance of vascular and "degenerative" diseases in morbidity and mortality statistics has given rise to an intensification of efforts to discover causative and therapeutic facts concerning arteriosclerosis. That cholesterol is in some way related to arteriosclerosis has long been obvious, since crystalline deposits in the walls of affected arteries have been repeatedly identified as cholesterol. However, the nature of its role in the deposition process is far from clear. Thus it may be that the fat crystals in atheromatous lesions are a secondary product of injury, analogous to the calcium salts which are often laid down at sites of chronic infection. On the other hand, the entrance of cholesterol in an abnormal quantity or physicochemical state into vessel walls may be the primary cause of intimal or medial degeneration.

Insofar as is possible this discussion will be limited to the role of cholesterol* in degenerative vascular disease, and in particular to a consideration of certain aspects which seem of particular pertinence or interest at this time. Theories regarding the origin of arteriosclerosis are many and conflicting. At this time none are complete enough or well enough confirmed to be universally applicable. Impartial observers seem inclined to agree with Gubner and Ungerleider,¹³ who say "... there is no single cause, *sui generis*, of arteriosclerosis. Rather the evolution of the arteriosclerotic lesion appears to be due to

multiple factors mutually interrelated in a dynamic mechanism."

In the evaluation of experimental studies involving the production of arteriosclerotic changes in animals, it is of vital importance to remember that the metabolism of fats is not identical in all species. For example, rabbits, although not ordinarily subject to arteriosclerosis, develop atheromata if fed cholesterol.³ However, under normal circumstances rabbits have low serum cholesterol values and consume negligible quantities in their usual diet, so that the significance of this finding in relation to the pathogenesis of similar defects in carnivores is not easily defined.²⁵ Similarly the lipid metabolism of birds differs markedly from that of mammals,⁶ and the comparison of data must always be qualified accordingly. The distribution pattern of experimental lesions is similarly important. Thus atherosclerosis in dogs is quite comparable to that seen in humans, whereas the sites of induced atheromata in birds and rodents are different.²⁵

In the course of the last fifteen years two important advances in the study of fat metabolism have offered promise of major advances in our knowledge of health and disease. The first, the application of isotopic tags to molecules involved in biochemical exchanges, has already served to clarify much that was previously not understood regarding the synthesis and transport of cholesterol. The second, the development of practical techniques for the preparation of fats for parenteral administration, is already yielding much information^{5, 19, 20, 26} and has vital therapeutic potentialities once satisfactory criteria for the administration of these preparations are established. Thus isotope studies, by revealing the ubiquitous nature of cholesterol precursors, have served to explain the difficulties encountered in attempts to modify serum levels and body stores of cholesterol through alterations in the exogen-

*Read before the Section on Medicine of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.

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*Although the term "cholesterol" is used throughout this paper to denote the lipid substances found in arteriosclerotic lesions, particularly in atheromata, studies by a number of authors have demonstrated that the fatty materials in the deposits are actually approximately the same as those in serum (cholesterol, neutral fats, and phospholipids). "Cholesterol" remains in general usage as a vestige of an era when techniques for the identification of tissue fats were rudimentary.

ous supply of fat.²⁵ By the parenteral administration of fats to animals, much information about the tolerance of animals to abnormal amounts of cholesterol has already been obtained.^{5, 15}

Hueper¹⁶ and others^{10, 27} have made important contributions to our thinking by demonstrating the importance of the *state* of the cholesterol as well as the *quantity*. Thus the relatively crude analytical methods in general use today indicate little more than the total quantities of lipid fractions present. The possibility that the fats involved in the production of arteriosclerosis differ physically, or even chemically, from those circulating in normal persons cannot be lightly dismissed. Indeed, it would be surprising to discover that this was untrue. Thus the size of particle, the relation to binding proteins, the chemical composition of fats and their plasma solubility will all obviously play important parts in interactions with vessel walls.^{16, 22, 27}

The importance of nutritional status in the incidence and severity of arteriosclerosis³⁰ does not justify the conclusion that increases in fat intake *per se* are responsible for arterial damage.

The basic laws governing the physicochemical activities of solutes in contact with permeable membranes imply that increases in the lipid concentration of serum will result in increased amounts entering arterial walls. However, actual measurements of cholesterol in vessels of humans with varying degrees of lipemia fail to reveal a simple, direct relationship, although there does seem to be considerable correlation once arterial disease is established.⁹ Similar mechanical considerations justify the expectation that increases in blood pressure will cause cholesterol to be forced through the intimal membrane in greater quantity than normally.¹³ This is perhaps confirmed by the frequency with which hypertension is complicated by vascular sclerosis.^{9, 13, 25}

Difficulties in inducing the diabetic state in animals susceptible to arteriosclerosis have up to the present rendered experimental approach to the role of diabetes in the causation of arterial disease extremely difficult. Recently one report has appeared.⁸ Instead of the expected accentuation of atheroma formation, these observers report that, under certain circumstances, diabetes may actually protect against cholesterol atheromas. This work on alloxan-treated animals is altogether out of keeping with clinical observa-

tions in humans, and will doubtless be a stimulus to further studies along this line.

For obvious reasons it is not feasible to cite all the factors involved in the production of arteriosclerosis. Among these, trauma and emotional strain are frequently implicated but difficult to investigate.^{12, 14}

Clinical Considerations

Arteriosclerotic lesions, be they atheromatous (intimal), of the Mönckeberg type (medial), or arteriolar, may exist in humans in varying degree at any age in either sex.¹⁸ Despite the ubiquitous nature of these vessel defects in man, their incidence in various groups is modified by many factors. Thus they are seen with increased frequency with advancing age, in obese individuals, and in certain disease states such as diabetes, hypertension, and hypothyroidism. In contrast, the inhabitants of areas where living standards are low, e.g., South Asia, Central Africa, and post-war Europe, allegedly experience relatively less arteriosclerosis (but also less hypertensive disease).⁴ Accurate analysis of the relative importance of caloric deficiency and of low fat intake is not available. Wilens has shown that in America the incidence in malnourished persons is significantly lower than it is in normal individuals.³⁰

Although, as has been indicated, there is a considerable body of evidence suggesting a correlation between serum fat concentration and mural fat deposition under certain circumstances,^{9, 12, 15} most contemporary workers are of the opinion that serum levels are not the primary etiologic factor in humans, and are frequently not related to the degree of involvement.^{1, 2, 9, 21, 24, 27} The difficulties involved in clarifying this relationship are obvious when one notes that the conditions in which atherosclerosis is commonly associated with high serum fat concentrations, e.g., diabetes, nephrosis, and hypothyroidism, are mainly those in which metabolic disturbances are of such a widespread nature that the specific role of fat is not easily separated from that of other variables.

In diabetes the high incidence of vascular disease is not easily attributable to hyperlipemia alone. Although Joslin²⁷ and White²⁸ have reported that improved control of diabetes affords a relative protection from these complications, the findings of others^{7, 28} indicate that even in competent hands the occurrence of such disturb-

ances is virtually inevitable in diabetics treated over long periods on accepted régimes. Moreover it is felt by some that overtreatment of diabetes contributes significantly to the high incidence of vascular disasters seen in victims of this condition.¹¹

Prophylaxis and Therapy

On one point all observers seem to be in agreement, and that is that obesity increases human vulnerability to arteriosclerosis. Furthermore, Wilens³⁰ has presented inferential evidence that arterial atheromata are reversible in wasting disease. Therefore, the question of what one may accomplish in attempts to reverse, or at least to arrest, the formation of vessel defects is important. Mortality statistics have long since offered convincing evidence of the adverse effects of excessive poundage on statistical life expectancy, so that the physician's primary efforts should be aimed at the prevention of obesity. Once it is present, the findings of Wilens suggest that removal of excess weight may offer patients the possibility of a less vulnerable vascular tree. However, as Hueper¹⁶ and Anderson¹ have pointed out, reduction régimes, if too stringent, may theoretically be inadvisable because of the increased transport of fat stimulated by starvation. This danger has been given added theoretical importance by Wilens' demonstration that structural alterations in atheromata may take place at a relatively rapid rate.³⁰

On the assumption that hyperlipemia is instrumental in the causation of arterial disease, procedures for lowering serum cholesterol have been suggested.^{1, 13, 16} Unfortunately the proposed programs have a number of limitations. Not only is the etiologic hypothesis as yet unconfirmed but, in addition, practical difficulties must be considered. Thus the removal of biliary secretions as a means of siphoning cholesterol from the body¹³ is uncomfortable and would involve a number of other difficulties similar to the digestive complications of biliary fistulas. Proposals for altering dietary habits in this country, however sound they may be in theory, would imply virtually insuperable obstacles in our traditionally "meat and potatoes" population. Most important of the obstacles to any such effort to alter the serum lipid concentration for prolonged periods is the versatility of the unknown homeostatic mechanisms in restoring original serum concentrations despite therapeutic alterations.¹³

This is, indeed, not altogether surprising when one realizes how intimate a part the metabolism and transport of fat play in virtually all aspects of mammalian energy exchange and storage.²³

Conclusion

In summary, the following attitude towards the role of fats in the production of arteriosclerosis seems to be in keeping with present-day known facts. Although in animals, under proper conditions, cholesterol may cause arteriosclerosis, in human disease its function in the pathogenic sequence has not been completely defined. Increases in dietary or in serum fat seem to accelerate the development of lesions, as does obesity. Weight reduction, while ineffective in permanently reducing serum cholesterol, is probably a valid and valuable method of modifying the development of atheromata, and perhaps in causing reversible lesions to regress. More specific methods for modifying fat metabolism to the advantage of the patient are either not yet available or are as yet in experimental status only. In diabetes the significance of disturbed fat metabolism in the genesis of arterial disease is even less clear-cut than in the non-diabetic.

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ONE-MINUTE CASE REPORT

Prepared by the Commission on Diabetes of The Medical Society of the State of Pennsylvania

CASE VII

Intercapillary Glomerulosclerosis

(Reading time 65 seconds)

A white male, age 57, had been a known diabetic for more than seven years when he was first seen in 1944. At that time his blood sugar was 122 mg. per cent two hours after lunch and his urinalyses were negative. He weighed 196 pounds and his blood pressure was 140/80. General physical examination was essentially negative except for a few small petechial hemorrhages and exudate in eyegrounds of both eyes and some scattered and peripheral lens opacities. Control of the diabetes was never much of a problem.

Ten months later both ankles began to swell slightly at the end of the day. An electrocardiogram was made elsewhere, and he began making the rounds of the doctors. He was told that the swelling was due to varicose veins and ligation was suggested. This he refused. Anticoagulants were tried and he was placed on a low sodium diet, all without relief. He was also given diuretics repeatedly by mouth and intramuscularly with little effect.

One physician suspected the true diagnosis and made a blood protein determination. The total serum protein was 4.1, albumin 2.5, and globulin 1.6 grams per cent. The urine showed 3 plus albumin.

The diagnosis was intercapillary glomerulosclerosis called Kimmelstiel-Wilson's syndrome. The complete clinical picture is anasarca, azotemia, retinal arteriolar disease, hypoproteinemia, hypertension, albuminuria, and mild diabetes of some years' duration. The diagnosis could have been suspected had a routine urinalysis been done.

There is no effective therapy for this disease, but correct diagnosis prevents needless laboratory examinations and worthless medications.

DOCTORS LIVE TO AN AVERAGE 67.2 YEARS

The *Journal of the American Medical Association* reports that it published the obituaries of 3331 physicians during 1949, an increase of 101 over the number published in 1948.

"This," the *Journal* explained, "does not represent the total number of deaths among physicians in 1949, but only the total number of obituaries published."

The average age at death among the 3331 physicians was 67.2 years. This is 0.2 year less than the average age of 67.4 reported for 1948 but higher by 0.5 year than the average age for 1947. The ages of the decedents ranged from 21 to 99 years; the largest number of deaths occurred between 70 and 74.

Heart disease was the leading cause of death, with a total of 1375 deaths, or 41 per cent. Of these, 706 were due to coronary occlusion, embolism, and thrombosis, 172 to angina pectoris and other coronary diseases, 273 to diseases of the myocardium and endocardium, and 224 to other diseases of the heart. The average age at death from diseases of the heart was 66.8 years, slightly lower than the average age of 67.5 years in 1948.

Diseases of the nervous system caused 432 deaths. The average age at death from this cause was 70.2 years, 0.2 year less than the average age for 1948. Nine physicians died from Parkinson's disease and 7 from meningitis and diseases of the spinal cord. Four hundred and five, or 12 per cent of all deaths, were caused by cancer and other malignant tumors; 157 were of the digestive system, 47 of the respiratory system, 74 of the genito-urinary system, and 127 of other and unspecified sites. Physicians died at an average age of 68.0 years from cancer, a 0.6 year increase over 1948.

Accidents caused 138 deaths among physicians, which was a decrease of 20 per cent from the number reported in 1948. Sixty deaths were due to motor vehicle accidents, 10 to airplane accidents, 28 to falls, 4 to poisoning by liquids or solids, 7 to drowning, and 3 to firearms. The average age at death from accidents was 58.9 years in 1949 and 57.2 years in 1948.

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THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

KEYSTONES OF PUBLIC HEALTH IN PENNSYLVANIA

Administrative Personnel

(EDITOR'S NOTE: This is the third of a series of guest editorials planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.)

The survey report on the Pennsylvania Department of Health prepared at the request of Governor Duff and Secretary of Health Vaux, entitled "Keystones of Public Health in Pennsylvania," contains a chapter on Personnel Administration which clearly reveals the great amount of careful investigation which went into this aspect of the Health Department. The chapter is well organized into several distinct aspects of the personnel administration which have been summarized under the following headings: recruitment of workers, permanence of employment, equality and adequacy of pay, impartial treatment of workers, and provision for economic security upon retirement.

Recruitment of Workers

Two methods are used for recruitment. The administrator may search among training institu-

tions and professional groups for qualified candidates, or he may select a candidate from the Governor's office personnel file. There is difficulty in recruitment of qualified top level personnel, because of the fact that appointees must be residents of Pennsylvania, and because political sponsorship must be secured.

About 90 per cent of the workers are selected under the patronage system and 10 per cent under the merit system. The Civil Service Commission's approval of a merit system appointment must be followed by sponsorship by the proper party official, either prior to appointment or shortly afterwards.

The report recommends strongly that the Health Department seek legislation which would provide the merit system type of personnel selection for the entire Department of Health and that the advice and guidance of the National Civil Service League be sought to write the necessary law or laws.

The report further recommends that the Department of Health undertake a reclassification study of all positions in the Department of Health for the development of uniformity, consistency, and conformity with modern standards. In the absence of a qualified personnel officer, the study might be assigned to a qualified consultant who would use departmental resources. The

study should be approved and sponsored by the Executive Board prior to undertaking it.

Permanence of Employment

The statement is made that "once on the job the employee now has to be responsored periodically, is subject to appeals for work during campaigns and, in spite of the Anti-Macing Act passed in 1939, must make contributions for the campaigns. It is virtually impossible, however, to remove a sponsored individual once he is on the job, no matter how poor his work is, so long as he maintains his contacts with his party sponsor."

Equality and Adequacy of Pay

There are many instances of inadequate salaries, and the report recommends that a study of salaries be undertaken for the workers in the Department of Health and that temporary adjustments be made prior to a more comprehensive study which should lead to a satisfactory compensation plan. The study might well be undertaken by bureau directors and division chiefs acting in committee.

Impartial Treatment of Workers

Civil Service employees have the right to appeal many personnel actions such as demotion, transfer, dismissal, failure in examinations, and the like. For 90 per cent of the employees of the department, such rights are not enjoyed.

Fair treatment of personnel is best accomplished through the services of a competent personnel administrator. The report recommends that the Secretary of Health seek the services of the Civil Service Commission in recruiting a qualified, fully trained and experienced director of personnel.

Provision for Economic Security Upon Retirement

A retirement plan for all state employees is in operation.

Summary

The report states that, because of numerous reasons, it seems undesirable now for the Health Department to continue to try to operate a merit system through the present Civil Service Act. The Health Department needs a civil service act which will create an advisory, as opposed to an administration, commission, an act which will

permit nation-wide recruitment of professional workers and not restrict recruitment to Pennsylvania or to county residents, an act which will permit the requirement of specialized training and education, an act which will provide for personnel administration on the basis of merit. The present merit system rules and regulations are adequate, except for the coverage of employees. Pending civil service provided by legislation, it is recommended that the Health Department rewrite the coverage provisions of the merit system rule to provide coverage for all Health Department employees and ask the Civil Service Commission to administer the rule.

The chapter ends as follows:

It is recommended that:

"The Secretary of Health request the support of the Pennsylvania Merit System League in developing a sound program of personnel administration for the Department of Health—this request to be addressed to the Public Charities Association in order to convene the League.

"Public health in Pennsylvania will be effective and worth while only so far as the quality of the workers in public health permit it to be. The official public health agency of the State cannot afford not to have a program of personnel administration which will provide it with the best qualified public health workers available. Toward that end this report has been directed."

I. HOPE ALEXANDER, M.D., *Director*,
Department of Public Health,
Pittsburgh, Pa.

THE NEED FOR PHYSICIANS IN OUR LEGISLATURE

"The time has come when physicians must put aside their prejudices against participating in politics and take a very active part in this line of endeavor.

"Contributing money to political party support does not accomplish enough toward winning support for our program.

"We find that we must be on the job all the time if we expect to protect the public interests. Recently, in conversation with one of our lead-

ing state politicians, he made the statement that if there were two physicians in each house of the legislature we would never have to worry about being able to defeat any adverse legislation.

"At present we are facing three very pressing problems: (1) the lowering of the standards of requirements for the practice of the healing art; (2) the starting of state medicine; (3) the continuance of our fight to improve health conditions for the public. There has never been a time when these problems were more urgent.

"We have a real fight on our hands in the 1951 state legislature and we need more than financial support. Doctors are needed in our legislative bodies who can command the respect and support of their fellow members. In this way we can accomplish much.

"In closing, I should like to urge all doctors who can possibly do so to file for the legislature early and make a strong campaign for election. I am lonely and need some of my own kind with me."

The foregoing was written by Walter F. Kelly, M.D., a member of the Indiana State Senate, and printed in the January issue of the *Journal of the Indiana State Medical Society*. A similar situation exists in our state. Here in Pennsylvania the medical profession is represented in the State Legislature by only two physicians—Dr. Leroy E. Chapman in the Senate, and Dr. George J. Sarraf in the House of Representatives.

Dr. Chapman, who practices in Warren, has represented the forty-eighth senatorial district consisting of Venango and Warren counties since 1931. Dr. Sarraf, who practices in Pittsburgh, has represented the second legislative district of Allegheny County since 1935.

In 1935, just fifteen years ago, when Dr. Sarraf joined Dr. Chapman, the medical profession had 11 other members in the General Assembly. Drs. I. Dana Kahle, Clarion County; Patrick J. Henney, Allegheny County; Leo C. Mundy, Luzerne County; George A. Deitrick, Northumberland County; and George Woodward, Philadelphia County, were in the Senate. In the House of Representatives were Drs. Emlyn T. Davies, Lackawanna County; Audley O. Hindman, Washington County; Albert F. Merrell, Susquehanna County; William W. Serrell, Forest County; Thomas E. Shea, Philadelphia County; and Albert J. Valibus, Luzerne County.

No doubt both Drs. Chapman and Sarraf feel as lonesome as Senator Kelly does in Indiana. All of us cannot run for legislative office, but we can all register and vote in the spring primaries for candidates who have committed themselves to the legislative program of The Medical Society of the State of Pennsylvania. Every doctor must openly advocate to his fellow citizens that they give their support to candidates who stand for voluntary insured sickness service and hospital care whether it be for profit or non-profit.

A. H. S.

THE PRACTICE OF CHIROPRACTIC IN PENNSYLVANIA

The medical profession's desire to maintain a high standard of education for those practicing on the human body is the one purpose behind attempts to establish legal educational requirements and licensure for chiropractors.

Low standards of education, obtained by many chiropractors now practicing illegally in Pennsylvania, increase the possibility of mistakes in diagnosing and treating human ailments. Consider the Pennsylvania law providing for the licensing of these individuals. Since 1914 the Medical Practice Act of Pennsylvania—administered by the Board of Medical Education and Licensure appointed by the Governor—has contained provisions to protect the public from untrained practitioners of limited forms of the healing arts. The definition of medicine and surgery in this act includes all forms of the healing arts.

Doctors of medicine have high educational standards and readily conform to them. Many chiropractors do not conform to the *minimum* educational requirements.

Section 6 of the Medical Practice Act provides that the Board of Medical Education and Licensure shall establish educational requirements and examine those who pretend to a knowledge of a limited branch or branches of medicine, also supervise their schools. A large number of chiroprodists, physical therapists, and drugless therapists (which includes chiropractors) have been licensed.

Limited licensees, known as "drugless therapists," include those who claim the spine as their basis for cause as well as for treatment of human illnesses. This law also regulates other healing

groups which may spring up claiming systems of diagnosis and cure which cast aside other well-established causes of illness.

Educational requirements for drugless therapists are: (1) preprofessional—a four-year high school course or its equivalent, one year of college chemistry, biology, and physics; (2) professional—three years in a recognized college of drugless therapy.

The preprofessional credits are the stumbling block to many chiropractors. These credentials are passed upon by the Preprofessional Credentials Bureau in the Pennsylvania Department of Public Instruction before the State Examining Board receives any information about the applicant for licensure. Many applying are not even grade school graduates.

The State Board has recognized two schools of drugless therapy in the United States—the National College of Chiropractic in Chicago, and the Lincoln Chiropractic College of Indianapolis.

A number of chiropractic and naturopathic applicants graduated by other schools of drugless therapy have been required to take professional refresher courses, and in some instances refresher courses in preprofessional training prescribed by the State Board.

The State Board, as provided by the 1914 law, calls in reputable licensed chiropractors to assist in the examination of these applicants.

If the medical profession had a selfish interest or desired to suppress individuals wishing to practice a limited form of the healing arts, it would never have so early established these means for their licensure.

There are many chiropractors with varying degrees of training who have drifted into Pennsylvania and are now practicing illegally. These individuals are either unwilling or are unable to conform to the educational standards to obtain a license to practice. It is these individuals who desire to obtain a license by political influence and new legislation.

Act 525 was passed by the 1949 Pennsylvania Legislature, and the board of five chiropractic examiners is appointed by the Governor, two of whom are unqualified since they are not licensed. They will be influential in approving schools and licensing many individuals who are not qualified to obtain a license.

These two unlicensed individuals have been practicing illegally for many years. Now they assume the role of "little angels" according to

recent publicity in the *Philadelphia Inquirer* and are going to clean up the so-called chiropractic profession.

This Act 525 obviously may result in a large increase in the group of unqualified persons practicing on the unsuspecting public and bring about legislation to create separate licensing boards for many others.

Fallacious arguments were advanced during the debate on this chiropractic board bill on the floor of the 1949 House which would have been nullified if the House Committee on Professional Licensure had permitted a private or a public hearing regarding these two bills for the presentation of substantial evidence by both sides. In spite of repeated written and oral requests to the Committee on Professional Licensure by the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania, such a hearing was not granted.

The salient points in this whole controversy are:

1. Chiropractors have been licensed since 1914 under present laws if they conform to a minimum type of education.
2. A large number of chiropractors who are unwilling or unable to conform to these educational requirements are continually trying to obtain licensure by legislation and thus avoid the essential training.
3. The Medical Practice Act of 1914 doesn't deny the people of this state any form of treatment. There are more than 500 chiropractors, about 1100 osteopaths, and 494 physiotherapists who have conformed to the legal educational requirements and obtained a license to practice in their limited fields in Pennsylvania.
4. Chiropractors repeatedly cloud the issue by false propaganda, claiming the medical profession is discriminating against them when the real issue is that they will not conform to State laws and obtain a license.
5. Enforcement is lax because there are not sufficient funds appropriated by the Legislature to employ enough personnel and facilities.
6. The Board of Medical Education and Licensure has done all in its power to have these illegal practitioners conform to legal educational qualifications. It has developed refresher courses at Duquesne University, Bucknell University, and Beaver College. It has urged these people to take advantage of the courses and has been as

lenient as possible, bearing in mind the necessity of protecting the public.

7. The medical profession has no ulterior or selfish motive in its fight to protect the public from badly trained practitioners of any form of healing, and it will continue to present the true facts to the public and to the Legislature when permitted in order to check insufficiently trained individuals from trifling with the health of our people.

The McDevitt School under question in the recent newspaper articles in the *Philadelphia Inquirer* has been in existence for a long time. According to law and regulations, any college granting degrees must be approved by the Advisory Council to the Department of Public Instruction before the court will grant it a charter. The McDevitt School has never claimed to be a college, grants no degrees, and exempts itself from this provision by granting certificates or diplomas; therefore, it cannot be reached legally by the Department of Public Instruction.

C. L. PALMER, M.D.

BEWARE PROFESSIONAL ENDORSEMENT OF PROPRIETARIES

Your druggist will tell you that old-time prescription writing is a thing of the past; the bulk of the medicines he dispenses on doctors' orders are "trade name" proprietaries. The percentage of these runs well above 75 per cent. We are in a changed era: we are flooded with good and bad medical literature from pharmaceutical houses, our shelves are filled with samples, and our minds are in a confusion with trying to recall the trick names that each house has for its products. Often these names are so nearly alike that serious mistakes can be made.

One will note that, except for the names, each of the large drug houses puts out formulas which are almost identical; this is particularly true of the barbiturates. There is a surprising similarity also in the technique of marketing—the detail man will always be with us—and every morning's mail will contain a certain amount of advertising literature (scientific, pseudo-scientific, and otherwise) and samples.

Perhaps it is unfair to be too critical and to overlook the many contributions that the large

pharmaceutical houses have made to pharmacology. Certainly, drugs are now more conveniently and elegantly packaged than ever before; and certainly much pharmacologic research has been done that never could have been accomplished by less wealthy organizations.

The criticism at this time is upon the score of the clinical data accompanying the exploitation of new products. In many cases it seems too insufficient and too premature to support extravagant claims. Worse still are the apparently subsidized medical articles that accompany the advertising. It is apparently not difficult to obtain articles that have been published in medical journals where proprietary remedies are endorsed and recommended. There is every reason to be cautious in accepting the claims made in such articles. We still have an up-to-date U. S. Pharmacopoeia and an AMA Council on Pharmacy and Chemistry which can guide us in sufficient and reliable prescribing.

DOUGLAS MACFARLAN, M.D.

REVIEW OF CASES OF INTEREST TO PHYSICIANS DECIDED IN PENNSYLVANIA APPELLATE COURTS, TERM 1948-1949

(EDITOR'S NOTE: Mr. William A. Challener, Jr., who with his distinguished father has served the Allegheny County Medical Society as legal counsel—the latter through three decades, has prepared for the JOURNAL the appended brief review which definitely should be of interest to doctors of medicine. The series will be completed in the March JOURNAL. Watch for it!)

Fees for Service

Following the death of a patient a physician is not permitted to testify to the services he rendered the decedent in order to establish his claim for services against the decedent's estate. This prohibition does not prevent the use of books of original entry to establish the nature and value of the services.

In *McKeehan Estate* (358 Pa. 548), to establish his services, the physician presented the testimony of his secretary and office assistant, his day or engagement books, the progress notes pertaining to Mrs. McKeehan, and the records of the Harrisburg Hospital. The Supreme Court held that this testimony of his secretary, books and records were properly admitted in evidence to prove the number of visits and treatment prescribed, and since they were made contemporaneously with the acts to which they purported

to relate, they were made under circumstances which suggested no motive for falsification and they were made by persons having knowledge of the facts set forth.

In the *McKeehan* case the services had been rendered during a period of sixteen years. During this time numerous visits had been made at the patient's home, at the physician's office, and at several hospitals. Blood counts, urinalyses, and physical examinations had been done, but the patient at no time paid for the services and the doctor, who was a nephew of his patient's deceased husband, who had been a physician, never rendered any bill.

It was argued, in opposition to the claim, that the evidence established that claimant intended the medical services to be gratuitous, and, therefore, the lower court erred in making any award whatsoever. In holding that there was sufficient evidence to establish that the claimant did not intend that his services were to be free of charge, Mr. Justice Drew, speaking for the Supreme Court, said:

"It is well settled that while there is an implied agreement to pay for the services of a physician, if the services were intended to be and were accepted as a gift or act of benevolence they cannot, at the election of the physician, create a legal obligation to pay. . . . Ordinarily, an implied promise exists to pay for services rendered and accepted, and the burden is on the person denying liability to show no debt was, in fact, intended."

"In the absence of an express agreement as to amount, the law implies a promise to pay for a physician's services as much as they are reasonably worth. . . . physicians should not have their services valued as you would commodities in trade by a fixed standard; what would be a proper charge for the same service to a man fully able to pay would be excessive to a man of limited means, and what would be willingly done for the indigent without thought of financial reward should be compensated for by one who can afford to pay on the scale which doctors of repute measure as the proper one."

Osteopaths

In *Palmer v. O'Hara* (359 Pa. 213), the distinction is drawn between the practice of medicine and the practice of osteopathy. The broad question in that case was whether the issuance by a licensed osteopath or osteopathic physician

of a certificate committing a mentally ill person to a hospital for mental diseases for care and treatment constituted an unauthorized practice of medicine. More specifically, is a duly licensed osteopath a "qualified physician" within the definition of Section 103 of the Mental Health Act of 1923 so as to be entitled (under Section 302 of the same act) to certify persons for commitment as mentally ill and in need of treatment and care in a hospital for mental diseases?

These questions were answered in the negative, the Supreme Court holding that osteopaths or osteopathic physicians are not "licensed to practice medicine in this State" within the intent of the Mental Health Act of 1923.

Hospital Records

Hospital records if properly proved are admissible in evidence, but not for all purposes or as proof of all the facts set forth in those records. Thus in order to make the "record of an act, condition, or event" contained in a hospital record competent evidence under the Uniform Business Records as Evidence Act of May 4, 1939, P. L. 42, the act, condition or event must be pathologically germane to the physical or mental condition which caused the patient to come to the hospital for treatment. Accordingly, a declaration by a hospital patient as to the color or identity of the man who shot him is not competent evidence.

In addition, ordinarily hospital records are not admissible in evidence unless they were made contemporaneously with the acts which they purport to relate; there must have been present at the time no contemplative motive for falsification and they must have been made by a person having knowledge of the facts set forth, or by one competent to predicate a medical and scientific opinion on the facts.

Travellers Insurance Company v. Heppenstall Company (360 Pa. 433) presented an example of the latter situation. In that case Leo A. Daines applied to The Travellers Insurance Company, on Aug. 22, 1945, for a policy of insurance upon his life in the amount of \$50,000. On Sept. 13, 1945, the policy was issued and on March 29, 1946, Daines died of a coronary thrombosis. Thereafter the insurance company attempted to cancel the policy on the ground that the insured had made false representations in his application for insurance as evidenced by certain notations in a hospital record.

In his application for insurance, the insured

had denied any previous dizziness or that he ever had or had been told that he had disease of the heart. It appeared that in 1945 the insured suffered a dizzy spell while driving his automobile and went to a hospital where an electrocardiogram was taken on which a hospital intern made a diagnosis of "possible coronary."

In holding that the hospital record was not admissible, the Court said:

"The diagnosis by the intern was especially inadmissible in the absence of any knowledge as to his expert skill and capacity to render an

opinion, as well as because of the lack of any opportunity on the part of defendant to cross-examine his qualifications and the basis of his conclusions. . . . While some parts of the hospital record may have been admissible, it would have been error to admit the portion giving the intern's 'impressions.'"—(Concluded in March PENNSYLVANIA MEDICAL JOURNAL).

WILLIAM A. CHALLENGER, JR.,
Challener & Challenger,
Legal Counsel, Allegheny County
Medical Society.

EASTER SEAL RESULTS



Twenty-eight years ago a crippled child or a handicapped adult was an unusual sight. Not because there were no cripples, for it was believed that there were at least 6 crippled per thousand population, but because crippled adults, hopeless and helpless, had no place to go and nothing to do except live

out their lives.

Ignorance, poverty, shame, and indifference surrounded the handicapped with barriers which neither they nor their families could penetrate.

Special hospitals, convalescent institutions, camps, and custodial establishments—only 342 in number throughout the United States—had beds for only an estimated 16,000 of the more than 300,000 crippled children under 16 years of age.

Fewer than 2 per cent of the nation's crippled children were receiving educational advantages in facilities equipped for that purpose, and most of those were in eastern coastal areas. Only 40 special organizations—many of them local—were even interested in the multiple problems of the many types of crippled.

In short, a handicap was a cross to be borne throughout a lifetime of suffering for both the cripple and his family. Society as a whole little knew and little cared that hundreds and thousands of crippled children and crippled adults were innocent and unwilling prisoners in their own homes, confined not by bars but by beds and in some few cases by braces and wheel chairs, and resigned to the fact of being "different."

That was because society had not been told that there could be another kind of life for the crippled; that they could be helped to useful, self-satisfying living; that they could be aided to happiness; that they had a right to live fully—outside the walls.

Then, in 1921, the National Society for Crippled Children and Adults was founded. Following closely, the Pennsylvania Society for Crippled Children and Adults, an affiliate of the National Society, was organized in 1923. Gradually, county societies, all affiliates of the National and Pennsylvania Societies, were organ-

ized and began to take care of the needs of physically handicapped children. The work of all the groups is made possible by the annual Easter Seal Campaign which will open March 9 this year.

Through the annual Easter Seal sale the Pennsylvania Society and its county units provide physically handicapped persons with crutches, braces, clinical care, transportation to treatment centers, speech training, services of qualified physical therapists and orthopedic specialists, offer scholarships to help overcome a critical personnel shortage, and provide eight weeks of specialized care at Camp Daddy Allen and Camp Easter Seal, summer health centers in the Pocono Mountains and Laurel Hill State Park near Somerset, respectively.

As a result of this vast organization, the crippled are becoming a useful part of our world, making their contribution to the professions, to business, and to industry. They have been discovered as a tremendous national resource, waiting only for the magic touch of scientific rehabilitation and warm understanding to render them productive human beings.

Now we know that there are 8,000,000 handicapped children under 21; that there are 5,000,000 handicapped homemakers, and that in total there are 28,000,000 of our people who carry some type of disabling handicap.

They are no longer "different"; today, they are out from behind their bars. There is a growing number of organizations, hospitals, medical schools, and other institutions as well as research scientists, professional therapists, and medical specialists who are not merely interested but doing something for the crippled.

The handicapped are filling vital posts for which they are especially selected and trained, and in filling them are making themselves well-adjusted, happy persons. Little children also are being given a chance to share life with other boys and girls and an opportunity to overcome handicaps once deemed insurmountable.

The immense resources of the 2000 affiliated Crippled Children Societies throughout the nation, including the Pennsylvania Society and its 45 local affiliated units, are banded together in a working federation dedicated to finding the crippled, discovering new ways of restoring them to usefulness, and assisting in supplying the services needed to make them constructive, well-integrated members of a progressive and energetic society.



(The recipient's name is engraved on the back of this medallion, along with the words "Presented by the Blank County Medical Society—1950.")

Honored by Medical Group
Award for Humanitarian Service

Rotary Secretary Honored

Honored by Doctors

Build Public Relations with the Benjamin Rush Award

"To you, Mr. John Doe, on behalf of the Blank County Medical Society, I wish to present this token of our appreciation for your unselfish and humanitarian service to the citizens of this community in making our county a healthier and happier place in which to live."

"Dr. Jones, it is indeed an honor to receive this recognition from the Blank County Medical Society. I am extremely happy that the presentation could be made before my friends in the Lions Club who also have done a good job in the field of health."

Every county medical society should publicly proclaim its grateful appreciation to laymen and lay organizations for their humanitarian service in making their communities healthier and happier places in which to live.

This may be done by presenting one worthy individual and one organization each year with the Benjamin Rush Medallion as a token of your county medical society's appreciation of their arduous services. Their contributions need not be world-shaking or have state-wide significance.

Beyond the sound public relations value ac-

companying the presentation ceremony, you are provided with an opportunity to say "thank you" to everyone who has aided the cause of good health, even though the symbolic medallion is given to one person or organization.

Your county medical society is encouraged to make this an outstanding annual project.

Names should be submitted before March 31, 1950, in order that medallions can be prepared.

Local presentation ceremonies should take place before July 31, 1950.

All eligible individuals and organizations chosen to be so honored by their county medical societies will be considered for the Benjamin Rush State Award to be presented at our annual convention.

Details of selection and presentation are available from the Committee on Public Relations or the committee's field representatives.

The past fifty years will long be remembered as a half century of monumental achievement in the field of public health. The medical profession is to be congratulated for its contributions and at the same time should be willing to share the credit of public health progress with lay organizations and lay individuals who have fought side by side with the profession in the battle of sanitation, sickness prevention, and health education.

APPLICATION FOR MEMBERSHIP

To the officers and members of the County Medical Society, a component society of The Medical Society of the State of Pennsylvania:

Gentlemen: I hereby make application for membership in your Society, and, if accepted as a member, I agree to support the Constitution and By-laws of your Society and of The Medical Society of the State of Pennsylvania, and the Principles of Ethics of the American Medical Association.

The accompanying \$..... (which shall be returned if the application is rejected by the censors or by the Society) will include, when accepted, dues in the county society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

1. Place of birth
(If not born in the United States, are you a naturalized citizen of the U. S.?)

2. Year of birth

3. Graduated in medicine from
(Give name of college in full)

Year of graduation

4. State certificate issued by the Bureau of Professional Licensing at Harrisburg

(Date)

I have not previously held membership in any component county medical society except in County Society, State of in 19.....

I was transferred (resigned in good standing, expelled, or suspended) from the above society in 19.....

5. Name in full

Post office

Street and number

County

6. Recommended by

7. The undersigned censors of the Society, having fully considered (a) the above application and (b) the required information obtained from the Biographic Department of the American Medical Association, herewith recommend the ^{acceptance}_{non-acceptance} of the applicant as a member of the County Society.

8. Date, 19.....

County society secretaries should record and file above information on blue membership card furnished annually by the State Society. Forward this application form to the State Society Secretary when the applicant becomes a full member of the county society.

For the annual county society membership dues, which include also state medical society annual dues, you receive:

THE PENNSYLVANIA MEDICAL JOURNAL monthly, and package library service by mail upon request, disseminating advances resultant from medical research and clinical experience.

Assistance in defense against suits for alleged malpractice.

Participation in the Medical Benevolence Fund, which provides "for the relief of pecuniary distress of sick or aged members or the parents, widows, widowers, or children of deceased members."

Benefits to children of members, under certain distress conditions, from the Educational Fund.

Every qualified physician should unite with a county medical society:

Because such membership affords convenient opportunity for graduate education keyed to the constantly developing discoveries in the field of medicine.

Because of its purpose to co-ordinate the professional activities of the members for the spread of adequate medical service to all the people.

Because it unites the representative members of the medical profession, bringing due recognition through cooperative endeavors with other organizations in the best interests of improved community health and sickness service.

Because of its program of educational service to the public on matters of health and hygiene.

United effort obviously tends to overcome individual apathy and to stimulate one's activity in behalf of civic health and general welfare

The Educational Fund Now Available

As was announced in the December and January issues of the JOURNAL, the assistance of the Educational Fund is now available for children in need of its benefits because of the death or incapacitating illness or injury of the member parent.

RULES AND REGULATIONS OF EDUCATIONAL FUND

1. Applications will be received beginning January 1 each year until April 1 and such applications shall apply only to the beginning of the school year in September of that year.
2. All applications to be reviewed by the Committee on Educational Fund must come through the secretary of the component county medical society where the applicant resides and also one other member of that society who will sponsor the applicant.
3. All applications must be submitted on a form supplied by The Medical Society of the State of Pennsylvania and must contain the grades of the applicant and the endorsement of the principal of the school last attended by the applicant.
4. The Committee on Educational Fund may advance to the applicant a maximum of \$700 per school year, and such advance for each succeeding year must be recommended by the committee upon examination of grades made during the past year. No advance shall be for more than four years unless it be for training in a recognized school of medicine.
5. The applicant must agree to return as much of the advance as possible, without interest, beginning three years from the time of graduation or separation from school, so that the fund may be kept available to other future applicants.
6. The applicant must provide proof of admission to a school approved by the Association of American Universities.
7. Only under extenuating circumstances will this fund be used in any way to continue the education in high school and then only for the amount of money determined by the committee as necessary.
8. This advance shall be known only as "Scholarships of The Medical Society of the State of Pennsylvania."
9. If the applicant desires assistance in the second, third, or fourth year of his or her education, it is the duty of the applicant to furnish to the committee his or her grades of the preceding year and a letter of recommendation from the dean or supervising principal of the school signifying that his or her education should be continued. This information should be in the hands of the committee by July 15 preceding the opening of the school year.
10. All applications shall be held confidential in the hands of the Committee on Educational Fund of The Medical Society of the State of Pennsylvania.

For application forms, write to the Educational Fund Committee, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

PENNSYLVANIA HEART ASSOCIATION

Now in its first year, the Pennsylvania Heart Association is nearing its goal of having every portion of the State serviced by a county or regional affiliate. Within a few months, it is expected that 45 of the 67 counties will have become formally affiliated with the state body either individually or in regional groupings of their own selection.

In existence before the state group was chartered, the Philadelphia Heart Association, embracing Philadelphia, Delaware, Chester, Montgomery, and Bucks counties, became one of the first affiliates. Another large early affiliate was the Western Pennsylvania Heart Association which covers 24 western counties with Pittsburgh as the focal point.

From state headquarters, 106 Walnut Street, Harrisburg, other organization work is progressing rapidly. Among groups now being formed are the Schuylkill Chapter, the Northeastern Heart Association (including Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming counties); the Tri-County Heart Associa-

tion (including Dauphin, Perry, and Cumberland counties); the York County Chapter, the Blair County Heart Association, and the Lehigh Valley Heart Association (including Lehigh and Northampton counties). A chapter is being formed in Mt. Carmel which is expected to expand to include Northumberland, Montour, and Union counties.

Andrew B. Fuller, M.D., president of the Pennsylvania Heart Association, attributes this rapid expansion to the belief, held not only by doctors but by alert laymen, that the program of the American Heart Association can be more efficiently implemented by a strong, central state organization acting through its regional chapters.

He points out that, since the state group acts as an intermediary between the various community chapters and the American Heart Association, it can offer a more comprehensive reviewing of the national program of research.

In the educational program, the state body functions not only as a clearinghouse for the better distribution

of literature and materials but, more importantly, as a meeting place for ideas which, when adopted, can penetrate more rapidly to the educational outlets at the local level.

Dr. Fuller also suggests that while each local affiliate retains autonomy in the dispersal of its share of Heart Campaign funds, the state body is in better position to act in advisory capacity in the matter of community service. It will be able to bring the experience of each individual unit into rapid focus so that the results of any project locally conceived will quickly become the common knowledge of all affiliates.

Also, by reason of frequent meetings of the Pennsylvania Heart Association's board of governors, which is made up of one medical delegate and one lay delegate from each of the twelve councilor districts set up by The Medical Society of the State of Pennsylvania, plus several delegates at large, service programs valuable to the entire state can be originated.

Enumerated among such service programs are the following:

1. Employment and rehabilitation services.
2. Correlation of "Heart" endeavors with all other voluntary agencies to avoid duplication of effort and to implement existing projects of such agencies.
3. Maintenance of a directory of state-wide community resources, which is really a follow-up of the above, but which will take into consideration any supplemental work to be done in cooperation with the State Department of Public Health, the Commission for Handicapped Children, the Commission for the Chronically Ill, etc. The cooperation of this new organization with the Commission to Study the Control of Rheumatic Fever of The Medical Society of the State of Pennsylvania has already been offered.
4. Professional training, with the aim of helping to train medical investigators, nurses, public health workers, etc.
5. Public education, providing free access for lay groups such as the Parent-Teacher Associations to a library of pamphlets and films, the services of qualified speakers, and the use of all publicity channels, etc.
6. Case-finding facilities and follow-up services for the improvement of cardiovascular treatment.
7. Assistance in obtaining Federal cooperation for both the State as a whole and the individual chapters, as well as scrutiny of legislation concerning cardiac programs on both the federal and state levels.

"These are only a few of the objectives of the Pennsylvania Heart Association," stated Dr. Fuller. "The organization will endeavor at all times to maintain a flexibility and an adaptability to confront situations as they arise.

"From a sheer business standpoint, the state organization takes a great burden of administrative duties from the American Heart Association, leaving the latter more time and financial resources for its own fundamental programs of research, education, and service," said Dr. Fuller. "By the same token, it also relieves the local affiliates of much burdensome labor by acting as a central clearinghouse."

At the present time the Pennsylvania Heart Association and its affiliates are embarked on the 1950 Heart Campaign. Here again the practicality of the state body asserts itself by virtue of coordinating all campaign activities in the State, and by affording a central source of campaign supplies.

Officers of the state group are as follows: president, Andrew B. Fuller, M.D., Pittsburgh; vice-presidents, James M. Brittain, Esq., Philadelphia, John J. Walsh, M.D., Pottsville, and Thomas P. Tredway, M.D., Erie; secretary, Ralph L. Shanno, M.D., Forty Fort; and treasurer, Thomas E. Francis, Harrisburg.

The executive committee consists of Drs. Constantine P. Faller, Harrisburg; Louis B. LaPlace and William G. Leaman, Jr., Philadelphia; and Edward A. Bretbauer, Jr., Pittsburgh.

Members of the affiliated chapters are automatically members of the Pennsylvania—as well as the American—Heart Association. In those areas wherein regional groups have not yet completed their organization as chapters, direct membership in the Pennsylvania Heart Association is open to all physicians in good standing and to laymen approved by the board of directors.

Information concerning membership or assistance in the formation of a local chapter may be obtained at Association headquarters, 106 Walnut St., Harrisburg, Pa.

AMERICA'S WAY

Every March the American Red Cross goes to the people of this country for support of its program. This program entails responsibilities decreed by federal statute, responsibilities of national and international scope that continue both in war and peace.

The response of the people is voluntary. It is for each individual to decide how much he can give of his time and his money to assist in carrying out these responsibilities. No one says what the individual must do.

Yet the people—in the little towns, in the rural districts, in the big cities—accept the challenge year after year and voluntarily make the Red Cross responsibilities their business. They take pride in shouldering their neighbors' burdens when the sudden hurricane, the forest fire, the flash flood sweep away homes and possessions. No one tells them they *must* help. They respond to the needs of their fellows in the pioneer spirit of helpfulness that is their heritage.

The response of Americans, not only at fund-raising time, but throughout the year, to every part of the Red Cross program—blood, safety, service to veterans and the armed forces and their families, nursing, disaster, international activities, and other services—is never failing.

The men in industries and professions, the women in homes and in the business world, the boys and girls in schools and colleges make up the American Red Cross and work THROUGH it, give THROUGH it, with no sense of compulsion.

This is America's way.

Time to Register for—

Special Electrocardiography Course

Nurses' Auditorium, Harrisburg Hospital, Harrisburg

To be presented on seven consecutive Thursdays from 9 a.m. to 4:30 p.m.

May 11, 18, 25, June 1, 8, 15, and 22, 1950

Registration fee \$35.00—Registrations limited to 60

42 Hours of Intensive Instruction

Presented by the Commission on Graduate Education of

The Medical Society of the State of Pennsylvania

Enroll now before the quota is filled—use the form below

Special Electrocardiography Course Registration Form

TO THE COMMISSION ON GRADUATE EDUCATION,
230 State St., Harrisburg, Pa.

Please enroll me in the Electrocardiography Course to be given in the Nurses' Auditorium of the Harrisburg Hospital, Harrisburg, on Thursdays, May 11, 18, 25, June 1, 8, 15, and 22, 1950.

I am enclosing my check for \$35.00 made payable to The Medical Society of the State of Pennsylvania for my registration fee.

Name (print in full)

Street

City

Specialty (if any)

Signed _____, M.D.

38th Annual Secretaries — Editors Conference

From four to seven officers and committee chairmen from each of our sixty component county societies are invited, all expenses paid, to attend and take part in the 38th annual conference of county society secretaries and editors which will be held from 2 p. m., Thursday, to noon, Friday, March 2 and 3, at the Penn-Harris Hotel, Harrisburg.

It is hoped that all county society members will read the appended program and will agree that it proposes subjects for discussion about which the following county society officers and committees "should know the answers": president, president-elect, secretary, editor, chairmen of the Committees on Public Health Legislation, Public Relations, and Medical Economics.

PROGRAM

Designed for Those Who Should Know the Answers

THURSDAY, MARCH 2, 1950

REGISTRATION 12:30 TO 1:45 P.M.

P. M.

2:00 WELCOME—Thomas R. Gagon, M.D., *Vice-Chairman*, Board of Trustees, Presiding.

INTRODUCTION OF NEW COUNTY SOCIETY SECRETARIES AND EDITORS—Walter F. Donaldson, M.D., *Secretary-Treasurer-Editor*.

2:15 THE GRIEVANCE COMMITTEE PROJECT—Loris W. Jones, M.D., *First Vice-President*, and Lester H. Perry, *Executive Secretary*.

Question and Answer Period.

2:45 ENOUGH PRACTICING DOCTORS — WHEN? — William S. McElroy, M.D., *Dean*, School of Medicine, University of Pittsburgh, and *Ex-President* of Association of American Medical Colleges.

3:00 A SURPRISE PRESENTATION—Committee on Public Relations. (See and hear yourself characterized.)

3:30 CRITICISMS (Question and Answer Period)
—Opened by Mary Baker Davis, M.D., *President*, Lawrence County Medical Society.

P. M.

4:00 PENDING HEALTH LEGISLATION—C. L. Palmer, M.D., *Chairman*, Committee on Public Health Legislation.

4:15 GRADUATE EDUCATION—Charles Wm. Smith, M.D., *Chairman*, Commission on Graduate Education.

4:30 REPLIES TO PUBLICIZED CONDEMNATIONS OF MEDICINE'S PROGRESS by Drs. Francis F. Borzell, William Bates, and Howard K. Petry.

5:00 ADJOURNMENT.

6:00 RECEPTION.

6:30 DINNER (informal).

AFTER-DINNER PROGRAM—E. Roger Samuel, M.D., *President*, Presiding.

INTRODUCTIONS.

KNOW YOUR AMA—George F. Lull, M.D., *Secretary and General Manager*, American Medical Association.

Question and Answer Period.

ADJOURNMENT.

FRIDAY, MARCH 3, 1950

HAROLD B. GARDNER, M.D., *President-Elect*, Presiding

A. M.

9:30 "EMERGENCY MEDICAL CALL SERVICE" (200-word progress report from county societies).
COME PREPARED.

10:00 HOME CARE OF CONVALESCENT AND ELDERLY PATIENTS.

(1) Facilities for—Mrs. Benedict H. Birkel, *Woman's Auxiliary* to Lebanon County Medical Society.

(2) Advantages of—Richard R. Hoffman, M.D., *Lebanon, Pa.*

A. M.

10:20 DRAMATIZED PRESENTATION BY MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA.

10:40 CRITICISMS (Question and Answer Period).

11:15 STUDYING 1948 SURVEY "KEYSTONES OF PUBLIC HEALTH IN PENNSYLVANIA"—George S. Klump, M.D., *Chairman of Board of Trustees*, The Medical Society of the State of Pennsylvania.

ADJOURNMENT.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*
8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

COUNTY HONOR ROLL FOR 1950

The honor roll in this issue of the JOURNAL deals only with county society, state society, and AMA 1950 dues paid in full. It reflects an admirable determination on the part of county medical society officers and members alike to demonstrate early and objectively their interest in and loyalty to organized medicine from its "grass roots" to its finest flower. Considering the confusion and the delay incidental to the introduction of AMA dues, it is indeed remarkable that more than one-third of our county and state medical society membership paid the 1950 dues, including AMA dues, within four weeks from the time they became due.

At this writing the combined dues of 3741 members have been received, representing 32 component societies.

The following county societies had, before February first, collected 1950 combined dues from 33 to 70 per cent of their active members:

Allegheny	Franklin
Armstrong	Indiana
Berks	Jefferson
Bucks	Juniata
Butler	Lebanon
Chester	Montour
Clearfield	Northampton
Clinton	Northumberland
Columbia	Philadelphia
Cumberland	Warren
Dauphin	Washington
Delaware	York

A similar honor roll will appear in the JOURNAL for March, but the honor roll to appear in the April issue will be arranged on the familiar comparative percentage basis. Boost your own!

FINIS—AMA 1949 ASSESSMENT

With the following brief report the thirteen-month (January 1, 1949, to February 1, 1950) AMA collection campaign is brought to a close.

During that period Pennsylvanians provided a total of \$205,940 for the American Medical Association on the basis of a \$25 voluntary assessment accounting for 8237 devoted Pennsylvania members paid in full.

The figures by counties appeared in the Officers Department of the December and January issues of the PENNSYLVANIA MEDICAL JOURNAL. Subsequent payments have not altered any county percentage rating.

It is believed that only the California and New York state societies will have paid in more than has Pennsylvania. Our percentage-paid basis may be better than that of New York, which has more than twice as many members as Pennsylvania, but will undoubtedly fall below that of a number of the societies with a total membership expressed in three or four numerals. In 1949 the membership of only New York and Pennsylvania was expressed in five numerals.

MEDICAL EDUCATION DEFENDED

The *Journal of the American Medical Association* for Jan. 21, 1950, takes issue with recent attacks on medical education. It cites inaccuracies in statements and omission of pertinent facts in charges levied by some members of the American Conference of Academic Deans.

For example, enrollments of freshmen medical students this year numbered 6986, an increase of 298 over last year. The critics had reported "there were 6387 places to fill in the freshman class." Failures, the *Journal* says, run from 10 to 15 per cent instead of only 3 to 5 per cent, as reported to the conference.

The critics of medical education failed to point out that the physician population is increasing faster than the general population.

"The medical profession is fully aware of its responsibilities and is striving constantly to effect

improvements to meet the health needs of the nation. It was the medical profession that took the leadership in 1905 in raising the standards of medical education.

"Today, the profession is extending that leadership in many fields so that the public may benefit. One example is the survey of medical education now being made under the supervision of a committee appointed under the joint auspices of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association.

"This comprehensive survey will provide information on the preparation of students for the study of medicine, undergraduate work, and graduate and postgraduate training. No one who truly is interested in the welfare of this nation would want to see the adoption of plans which might cause a return to the medical chaos that existed forty to fifty years ago. If medical advances are to be continued, they must be made on the basis of careful study, planning, and experience."

INFORMATION ON AMA INTERIM MEETING

Appended are generous abstracts from the report provided to the Board of Trustees of The Medical Society of the State of Pennsylvania on the activities of the AMA House of Delegates in session December 6 to 8 by James Z. Appel, M.D., chairman of the AMA delegates from Pennsylvania.

Those who read these abstracts will better understand and appreciate more sympathetically the problems confronting the American Medical Association.

The Medical Society of the State of Pennsylvania was represented at the Interim Session of the AMA House of Delegates at its meetings in Washington, D. C., by ten regular delegates, namely, Drs. William L. Estes, James L. Whitehill, George S. Klump, James Z. Appel, E. Roger Samuel, William Bates, Francis F. Borzell, Harold B. Gardner, Charles L. Shafer, and Howard K. Petry. Also, Dr. James D. Stark, an alternate-delegate, was present in the place of Dr. Elmer Hess who was speaking on urology in Santiago, Chile.

Dr. Petry was appointed chairman of the Reference Committee on Legislation and Public Relations; Dr. Klump, chairman of a special Reference Committee on Insurance and Medical Service. These two reference committees received most of the controversial issues that came before the House of Delegates. The hearings of both committees were very well attended and the deliberations of the two committees were so thorough and their opinions so representative of the opinions of the House of Delegates that there was very lit-

tle debate on the floor of the House when they rendered their reports on these highly controversial issues.

Dr. Gardner was appointed a member of the Reference Committee on Reports of Officers and Dr. Shafer was a member of the Reference Committee on Medical Education. Dr. Bates served as a member of the Committee on Publicity of the House of Delegates.

Dr. Ernest E. Irons, president of the American Medical Association, gave a stirring address which was received with great enthusiasm. He emphasized many accomplishments of the National Education Campaign, dividing them into the effect on the medical profession, the public, and on the plans and strategy of the adherents of compulsory medical insurance. The future of the campaign was also briefly discussed. Dr. Irons stated that we must push on, utilizing the good relations already established with the press, radio, and friendly organizations but never failing to maintain as our strongest field in public relations the physician-patient relationship.

In the printed report of the Board of Trustees, in its supplemental report, and in an amendment to the By-Laws introduced by Dr. James C. Sargent of Wisconsin, a plan was developed establishing payment of dues as essential for membership in the American Medical Association. As a result of these parliamentary proceedings, the House of Delegates amended Chapter II of the By-Laws by deleting that portion which decreed that membership in the AMA continued so long as a physician was a member of his component society. As amended, annual dues not to exceed \$25 may be levied for each ensuing calendar year by the Board of Trustees of the AMA subject to approval by the House of Delegates—such dues to be paid by the members to the constituent associations, which in turn would turn them over to the AMA. As amended, a physician who had lost his membership by failing to pay such dues should in the process of reinstatement pay his indebtedness for such delinquency. A member loses his membership if he fails to pay his dues within thirty days after receiving a notice from the secretary of the AMA that his dues are delinquent for the period of the preceding year.

Dr. Louis Bauer, chairman of the Board of Trustees, then reported that the Board recommended to the House of Delegates that the dues for 1950 be set at \$25. This recommendation was approved by the House of Delegates unanimously. Dr. John Cline, of California, then moved that all physicians, regardless of age, who are actively engaged in the practice of medicine be required to pay dues except in cases of hardship, the Board of Trustees of the AMA to remit the dues if claim of hardship is approved. In the discussion of this motion, Dr. Cline stated that he believed that physicians who held full-time teaching and research positions should be considered in the active practice of medicine.

The Board of Trustees recommended to the House that "it would be inadvisable to eliminate the Fellowship classification." This recommendation was accepted.

Dr. Bauer, chairman of the Board, stated that upon the receipt of dues a certificate of membership in the AMA would be forwarded. He also said that all mem-

bers would be admitted to the meetings of the scientific assembly and section meetings. Prior to 1949 only Fellows of the AMA were admitted to these sessions.

The Reference Committee on Sections and Section Work reported favorably on the report of the Council on Scientific Assembly.

The Reference Committee on the Report of the Board of Trustees agreed with the Board that it would be unwise at this time to activate the recommendations of the Committee on Hospitals and the Practice of Medicine. Legal opinion obtained by the AMA considers some of the committee's recommendations to be contrary to previous court decisions. The reference committee recommended that the original committee (Dr. Hess, chairman) be reactivated and its report referred to the committee for rewording so that the philosophy of the report would be maintained but its wording kept within constitutional bounds.

The House of Delegates voted in favor of a resolution requesting information from the National Resources Council on the part that physicians were expected to play in the organization of civil defense and the need by the armed forces of physicians in case of a national emergency. It deferred action on a report of the Displaced Physicians' Committee.

The Reference Committee on Medical Education approved the report of the Council on Medical Education and Hospitals. This report pointed out that there has been an increase in residency positions available from a few more than 5000 before and during World War II to 17,293 on May 1, 1949. During the same period the number of hospitals approved for residency increased from 616 to 1187.

The same reference committee refused to approve several resolutions that were presented which recommended requiring from one to three years in general practice before becoming eligible for resident training and specialty board examination. The action of the reference committee was upheld.

The Reference Committee on Legislation and Public Relations opposed Bills S. 1453 and S. 1411, but pointed out that while some parts of each bill had much merit, both should be opposed because of inadequate protection against government interference with the administration of medical schools. New medical schools through generous financial aid for construction were unwisely favored by S. 1453, as were new schools over old schools in the extent of financial aid to new students. Bill S. 1411 was sound in regard to appropriation of moneys for school health examinations, but went too far in appropriating money for the treatment of school children, regardless of economic status, in whom defects were disclosed.

In regard to the dissemination of legislative information from the Washington office of the AMA to the Board of Trustees and thence to the Association at large, this reference committee recommended that a special coordinating committee of seven be appointed from the Board of Trustees and House of Delegates for the purpose of speeding up this dissemination of information. Recommendations of the reference committee were approved by the House.

The Reference Committee on Hygiene and Public

Health on the report of the Committee on Blood Banks pointed out that with the appointment of General Marshall as head of the American Red Cross it is believed that many of the stumbling blocks in the blood bank situation will be carefully investigated and corrections instituted. It disapproved of a resolution submitted to the House of Delegates calling for modification of the Harrison Drug Act to permit prescribing narcotics by telephone orders to druggists.

The Reference Committee on Amendments to the Constitution and By-Laws recommended the adoption of one amendment which would create, as a standing reference committee of the House of Delegates, the Reference Committee on Insurance and Medical Service. It disapproved a suggested amendment which would have prohibited general officers of the AMA from being elected to the office of president-elect.

The Reference Committee on Miscellaneous Business approved a resolution instructing the Board of Trustees to notify the constituent state associations that the House of Delegates was favorably impressed with the development of a Grievance Committee by the state associations of Colorado and Oklahoma and urging the other state associations to study the inauguration of one.

The reference committee regretted that it could not approve a resolution which recommended the payment of a per diem honorarium, in addition to expenses, to general officers, to members of the Board of Trustees, committees, councils and boards of the AMA for time spent in Association work excepting time spent while in attendance at regular or interim AMA sessions. The committee advised that a survey be made to make sure that the actual expenses of these loyal, hard-working members of the Association are adequately covered by the Association. It was believed that recompense for professional income lost would prove too difficult to determine and beyond the capacity of the AMA to pay.

A resolution requesting the Speaker and the Board of Trustees to appoint a committee of lay individuals to assist the Coordinating Committee for the Education Campaign received a favorable recommendation by the reference committee. This committee studied a resolution requesting the Board of Trustees to organize a Junior American Medical Association for medical students, interns, and residents; it recommended that the Board of Trustees study this project and report plans or organization to the House of Delegates at its June, 1950 meeting. The report of the reference committee was adopted.

The special Reference Committee on Insurance and Medical Service of the Council on Medical Service stressed the recommendation that "every county and district medical society participate actively in existing health councils in the communities and cooperate with existing lay groups in the establishment of such coun-

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cils where they do not exist." The reference committee agreed that each community in need of a physician should be impressed with the fact that it has a responsibility to offer attractions for a prospective physician, also that medical schools in the vicinity of such communities should offer inducements to physicians to locate in those towns by extending the courtesy of the school diagnostic and educational facilities to the physician.

This same reference committee also considered a resolution submitted by the Tennessee and Texas Medical Associations concerning the medical service and hospital care of veterans with non-service-connected disability in non-governmental hospitals. This same resolution was submitted to the 1949 House of Delegates at its annual meeting in Atlantic City and was referred to the Board of Trustees, which in turn appointed a Committee on Veterans Affairs to serve as a committee of the Council on Medical Service. The member of the Tennessee delegation who re-submitted this resolution maintained that no action had been taken by this special committee of the Council and requested that a special committee of the interim House of Delegates be appointed by the Speaker to study this problem and report to the House at its June, 1950 meeting. This recommendation and the report of the reference committee were approved by the House.

The chairman of the Board of Trustees of the AMA informed the House of Delegates that it had been decided to change the name of the magazine *Hygeia* to *Today's Health*. He also announced that Dr. Morris Fishbein, on his retirement, had been granted a pension for life of \$15,000 annually and a paid-up life insurance policy of \$50,000.

Dr. Elmer Henderson, chairman of the Coordinating Committee for the Education Campaign, gave a stirring address when he presented his very complete report on the activities, accomplishments, and plans for the future of his committee. Dr. Henderson stated that "the AMA cannot support or oppose candidates for public office. That is not the province of the AMA, nor that of state and county medical societies. But every doctor in his own community, if he believes in sound medical practice and if he believes in maintaining American freedom, not only has the right to support candidates who square with his convictions but he has a sacred obligation to do so.

"We have many fine, staunch supporters in both houses of Congress and in both parties. If they are willing to stand up and be counted on this issue, then doctors in their home districts ought to be equally willing to stand up for them when the chips are down. And we will need every doctor on the firing line."

Respectfully submitted,

JAMES Z. APPEL, *Chairman*,
Pennsylvania AMA Delegates.

THE HESS COMMITTEE REPORT

One of the most discussed items at the recent AMA Clinical Session was the report of the Hess Committee

of June, 1949. This committee had been given the task of considering ways and means of dealing with hospitals which were, in effect, practicing medicine. The hospital departments primarily concerned were those of radiology, pathology, and anesthesiology. In these departments, in some hospitals, medical services were actually being sold to hospital patients at a greater fee than was paid to the physician rendering the service.

The Hess Committee in its report to the 1949 annual AMA session suggested that Item V(3) of the "Essentials of a Registered Hospital," adopted by the AMA Council on Medical Education and Hospitals, be enforced. This item reads: "It shall not be the policy of the hospital to make a profit from the department of radiology." While the statement applies directly to radiology, the principle behind it is equally aimed at all branches of medical practice.

To implement this provision, the Hess Committee recommended that the Judicial Council of the AMA be empowered, upon due action by county and state medical associations, to determine which of the members of the AMA were unethical or which hospitals might be violating the clause. The Judicial Council, in the latter instance, would report to the Council on Medical Education and Hospitals, which would have the power to remove the name of the hospital from its registration list.

On consideration of this recommendation, the Board of Trustees sought legal advice and was given an opinion which held that such a procedure might be in violation of legal statutes. The board thereupon recommended to the House of Delegates that the Hess Committee report, which had been adopted by the 1949 House of Delegates, be rescinded. That was the question before the Clinical Session.

After considerable discussion before the trustees and before a reference committee, the House of Delegates was given the recommendation that the Hess Committee report be reconsidered, not rescinded. On a substitute motion, the reference committee's report was amended to provide that the original Hess Committee recommendations not be put into effect until after the 1950 annual session and that, prior to that time, legal aspects of the matter be reconsidered by the original Hess Committee for report to the 1950 House of Delegates. This amendment was adopted unanimously.

The interesting portion of the amendment is the statement which *reiterates the belief of the House of Delegates in the theory underlying the original report and the principles enunciated in it*. The House of Delegates has placed itself squarely on record that the practice of medicine is a personal professional activity and not a proper corporate endeavor. If radiology, pathology, and anesthesiology have already succumbed, what is to prevent surgery, obstetrics, and general practice coming next?

We will await with great interest the recommendations of the reappointed Hess Committee on ways and means of implementing the original report without infringing any statutes in so doing. It is sincerely to be hoped that a clear-cut answer on this question may be found and adopted.—*California Medicine*.

FOSTER HOMES FOR CARE OF THE AGED AND CHRONICALLY ILL

The medical profession has been repeatedly presented with the problem of the care of the aged and the chronically ill. The rate of increase of our aging population is much faster than the facilities being provided for its care. It is only in the past few years that considerable thought and effort are being given to the care of the chronically ill and the aged, and now we realize that facilities for their care are utterly inadequate. Statistics showing the trend in the aging of our population are all too well known and the figures so convincing that the medical profession and all related groups are faced with the urgent need of providing for these people.

Since at this time it is impossible to provide institutional care for all of them, and since it may require many years and huge expenditures before it is realized, it may be possible to alleviate the present acute need by expanding some of the present services. We are familiar with the home follow-up medical care program tried successfully by Bellevue Hospital and Montefiore Hospital in New York City. I believe that a similar plan may be employed, that of providing home care to many now in institutions and also that of expanding the program and facilities of the Department of Child and Family Welfare, including the procurement of foster homes for those requiring a minimum of medical care.

Many patients in homes for the aged and infirm, and also many in institutions for the chronically ill, may be suitable subjects for home or foster home care under adequate supervision, possibly under the joint auspices of the hospitals, Department of Welfare, and the medical profession. The greater proportion of the "guests" in the county homes require a minimum of medical care and a large amount of custodial care. We are acquainted with the fine work and satisfactory results obtained with thousands of children who have been placed in foster homes. They receive in these homes those intangible benefits which only a home provides, with a more normal environment, a more varied recreation, fewer changes in personal habits and less regimentation, greater interest in worldly affairs, etc.

This means of alleviating the present demand for institutional care of course would be applicable to selected cases. One must consider the individual patient—his emotional, physical, economic, family, and educational status. Certainly each case should be evaluated, preferably by a board or committee, including a physician, social worker, nurse, physiotherapist, etc. Perhaps this would lead to the formation of a "geriatrics" placement center, where it would be possible to evaluate a patient through a physical examination, social and occupational history, etc. The patient would then be classified as to his physical capacity, diagnosis, and amount of medical and custodial care needed.

In comparing the cost of institutional care, especially when one must consider the building, equipping, and maintaining of large physical structures, it seems much greater than the cost of care in homes or foster homes. It is not known what difficulties may be encountered in securing foster homes for the aged and the chronically ill, especially if some care and supervision is required,

but this suggestion should be considered for further study and possibly a pilot experiment may be tried. There may be many families or lone individuals who would have adequate facilities and interest to make possible extension of care in homes, with the cooperation of the welfare agencies, hospitals, and the medical profession.—LOUIS L. AMATO, M.D., in *Westchester (N.Y.) Medical Bulletin*.

CHANGES IN MEMBERSHIP

New (7) and Reinstated (6) Members

LEBANON COUNTY: (Reinstated) John F. Loehle, Lebanon.

LEHIGH COUNTY: (R) John Abbott and Thomas H. Weaver, Allentown.

LYCOMING COUNTY: Russell Wm. Pfeil, Montoursville.

PHILADELPHIA COUNTY: Harry W. Cohen, Robert Kaye, John A. Napoleon, and Charles W. Umlauf, Philadelphia. (R) Samuel B. Greenway and Edwin J. Kalodner, Philadelphia; Richard R. Lamb, Trenton, N. J.

WARREN COUNTY: William S. Walters and William L. Vogt, Warren.

Resignations (5), Transfers (10), Deaths (17)

ALLEGHENY: *Deaths*—Edmund C. Boots, Pittsburgh (Univ. Pgh. '20), December 24, aged 55; Richard H. Gollings, Pittsburgh (Hahn. Med. Coll. '36), December 11, aged 43; Samuel R. Haythorn, Pittsburgh (Univ. Mich. '04), December 6, aged 69; James D. McClure, Pittsburgh (Univ. Pgh. '92), recently, aged 84.

BEAVER: *Resignation*—Frank E. Schwartz, Pittsburgh.

BERKS: *Transfer*—Charles V. Dolan, Birdsboro, from Lancaster County Society.

BUTLER: *Resignation*—Saul Fortinoff, Butler.

CHESTER: *Death*—U. Grant Gifford, Kennett Square (Jeff. Med. Coll. '88), November 22, aged 87.

COLUMBIA: *Transfer*—James P. Sands, Laurel, Md., to Prince George County (Md.) Medical Society.

CRAWFORD: *Death*—Frank A. Clawson, Meadville (Chicago Homeo. Med. Coll. '99), recently, aged 71.

CUMBERLAND: *Transfers*—James H. Miller, Mechanicsburg, from Dauphin County Society; William J. Short, Newville, from Mifflin County Society.

DAUPHIN: *Transfer*—Fred S. Badman, Harrisburg, from Perry County Society. *Death*—Harry A. Lakin, Harrisburg (Univ. Md. '03), December 8, aged 73.

DELAWARE: *Transfer*—Blanche Melvain Kelly, Darby, from Philadelphia County Society.

GREENE: *Death*—Hiram C. Scott, Waynesburg (Jeff. Med. Coll. '03), December 13, aged 75.

LEHIGH: *Death*—William A. Hausman, Jr., Allentown (Univ. Pa. '02), November 25, aged 71.

LYCOMING: *Death*—Oliver W. H. Glover, Laurelton (Jeff. Med. Coll. '91), November 12, aged 81.

MONTGOMERY: *Death*—John B. Sherbon, Pottstown (Univ. Iowa '04), December 14, aged 73.

PHILADELPHIA: *Resignations*—Theodore L. Orloff, James F. Ward, and Robert S. Mutch, Philadelphia. *Transfers*—Richard R. Lamb, Trenton, N. J., to New Jersey State Medical Society; Wallace G. McCune, Philadelphia, from Washington County Society; Matthew T. Moorehead, Norton, Va., to Wise County (Va.) Medical Society; Malcolm C. Spencer, Danville, Ill., to Vermilion County (Ill.) Medical Society. *Deaths*—Augustus A. Eshner, Philadelphia (Jeff. Med. Coll. '88), December 20, aged 87; Tello J. d'Apéry, Philadelphia (Jeff. Med. Coll. '05), November 19, aged 73; George M. Dorrance, Philadelphia (Univ. Pa. '00), November 21, aged 72; Daniel Jos. Donnelly, Philadelphia (Temple Univ. '06), December 20, aged 74; Arthur P. Hitchens, Philadelphia (Med.-Chi. Coll. '98), December 11, aged 72; Orwan L. Latchford, Philadelphia (Med.-Chi. Coll. '03), December 17, aged 75; Julius L. Werner, Philadelphia (Jeff. Med. Coll. '05), December 11, aged 69.

WASHINGTON: *Resignation*—Frederick C. Stahlman, Charleroi.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Cumberland County	
A friend in memory of Dr. James Cochran ..	\$5.00
Woman's Auxiliary, Lehigh County	
A friend in memory of Dr. W. A. Hausman	15.00
Woman's Auxiliary, Montgomery County	109.45
A member, Philadelphia County Society	10.00
Previously reported	142.00
Total contributions since 1949 report	\$281.45

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since December 1. Figures in first column denote county society numbers; second column, State Society numbers.

Dec. 1	Philadelphia	3240-3247	10740-10747	\$67.50
	5 Philadelphia			
	(1950) 1-5		1-5	115.00
19	Montgomery	346	10748	15.00
	Montgomery (1948)			15.00
20	Lehigh	227-232	10749-10754	67.50
	Lebanon	6-9	10755	15.00
	Warren	(1950) 1-5	6-10	115.00

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Are you taking advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? There are, at the present time, over 103,000 reprints and tear sheets from current periodicals filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948, an increase of 293 requests over the total for 1947.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

The following requests were filled during the month of December:

Tumors of the cervix	Treatment of arthritis
Rh factor	Renal physiology
Rh factor in obstetrics	Isotopes
Rh incompatibility	Cancer clinics
Inversion of the uterus	Asthma
Adaptation syndrome	Poliomylitis
Venereal disease	Health services in Britain
Silicosis	Health insurance
Pseudomyxoma peritonaei	Nasal sinus infections
Seasons and diseases	Stillbirths
Lymphopathia venereum	Infant mortality
Multiple myeloma	Maternal mortality
Idiopathic steatorrhea	Beryllium poisoning
Atelectasis in children	Chemotherapy of cancer
Carcinoma of the skin	Boeck's sarcoid (2)
Intestinal intubation	Blood specific gravity
Hay fever	Treatment of keratitis
Tonsillectomy	Use of compound E
Behcet's syndrome	Ocular injuries
Acute leukemia	Potassium
Alarm reaction	Undulant fever
Rheumatic fever	Gangrene
Endometriosis	Functions of a library
Portal hypertension	Treatment of arthritis
Cerebral hemorrhage	Medical records
Animal experimentation	Erythema
Cardiospasm	Toxicology
Bacteriology	Allergy
Streptomycin	Abortion
Pneumonia mortality	Chronic ulcerative colitis
Microwave radiations	Epilepsy
Lower nephron nephrosis	Emotions
Lipoid metabolism	Leukemia
Public health nurses	Undulant fever
Voluntary health insurance	Eye refractions



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Exfoliative Cytology Fellowships

The number of fellowships in exfoliative cytology has been increased from 23 to 31 for the current year under revised regulations just announced by the American Cancer Society. Likewise, in keeping with the expansion of the undertaking, there are two additional laboratories available—one at the Washington University School of Medicine in St. Louis, under the direction of Dr. Lauren V. Ackermann, and the other at the Yale University School of Medicine, in charge of Dr. Samuel C. Harvey.

During the past year there has been an enthusiastic response on the part of fellows and directors of the laboratories where training facilities have been available. Many fellows set up their own laboratories, making officials hopeful that during the next year these fellowships may be filled again by qualified pathologists who will endeavor to organize laboratories of exfoliative cytology in their own hospitals.

Fellowships are awarded by institutions or laboratories designated by the Society to individuals on the basis of their past training and their intention to teach in their own laboratories diagnostic techniques in exfoliative cytology to interested pathologists, clinicians, and technicians. Each fellowship shall be awarded for a four months' period, and training may begin at any time convenient to the laboratory and to the fellow. The fellowships are not subject to renewal.

The stipends are paid in two sums: the first, a grant to the laboratory for tuition, overhead, and other expenses, and the second to the trainee to partially cover his board, room, and incidentals for the period of training. This latter sum shall amount to \$140 a month and shall be paid direct to the fellow.

Detection Centers

The Medical and Scientific Committee of the American Cancer Society has adopted a general resolution on detection centers which was passed at the Conference on Cancer Detection held last fall at Portsmouth, N. H. The resolution covered the following points:

1. The detection center was developed for the periodic examination of apparently well persons. This examination involves medical diagnosis, and has useful potentials in the detection of non-cancerous as well as cancerous conditions.

2. Experience has disclosed that detection center examinations of all citizens are not practicable; therefore, there is no opportunity for equitable distribution of funds, voluntary or otherwise, for such purposes.

3. It is recognized also that a large section of the public does visit a physician at least once annually. This includes physicians in private practice and in governmental and private agencies. If such physicians will perform office physical examinations on all patients, it is reasonable to expect that most accessible cancers in such

persons will be diagnosed at a much earlier stage than in the past with corresponding increased probability of cure. Further, it is desirable that every possible effort be made to provide examinations for cancer to those requesting these checkups. In brief, it is suggested that every physician's office or clinic become a "Cancer Detection Center."

4. In an effort to demonstrate the value of periodic examination of adults without signs or symptoms of cancer, it is suggested that appropriate agencies continue to support detection examinations for eligible cases. Such demonstration centers could also serve as sources of information on the true incidence of early cancer and as areas of investigation for improved diagnostic methods.

5. The competent screening of large numbers of persons for cancer (as distinguished from regular or usual medical examinations) deserves further trial as a possible approach to cancer control and it is believed that the program of mass screening will be better accomplished.

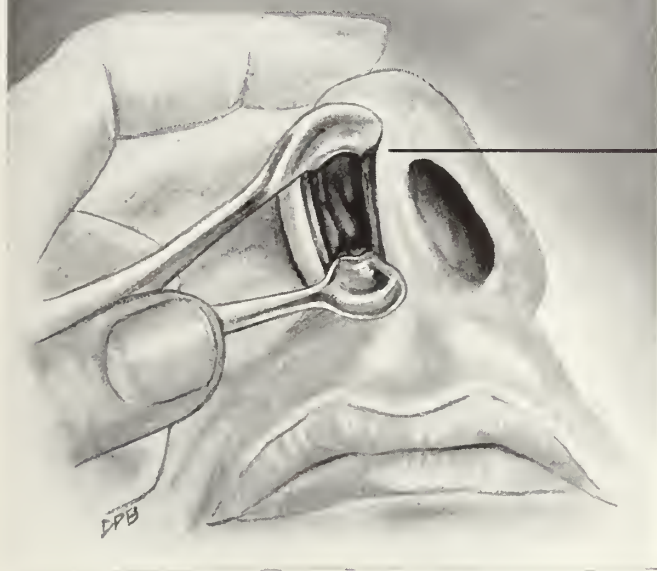
Proceedings of the Conference on Cancer Detection now have been published by the American Cancer Society, and while copies will be sent only to the participants, bound copies may be loaned for reasonable periods from the Pennsylvania Division, American Cancer Society, or from the Society's national headquarters in New York City.

Periodic Physical Examinations

The Roman physician Celsus once wrote: "Only the beginnings of a cancer permit of a cure." The recent advances of medicine have given this statement greater significance than it has ever had before. Modern surgical and radiotherapeutic methods, supported by such ancillary disciplines as anesthesia, chemotherapy, and nutrition, have, in the past eighty years, rendered one form of cancer after another curable, so that while Celsus' aphorism, at its writing, was of practical importance for only a few superficial forms of cancer, it has become meaningful and utilitarian for virtually every expression of the disease.

While the value of periodic physical examination had been recognized and, in a general way, advocated by physicians and life insurance companies prior to 1922, it was in that year that the first formal, although transient, attempt was made to examine large numbers of presumably well persons for evidence of cancer. In 1933 the first permanent clinic for this purpose was established. This attempt to lower the threshold of apprehension of early cancer has resulted in the establishment of 251 clinics or centers in the United States functioning specifically for the detection of cancer. While most of these are of recent development, it is probable that the aggregate results may now be profitably examined.

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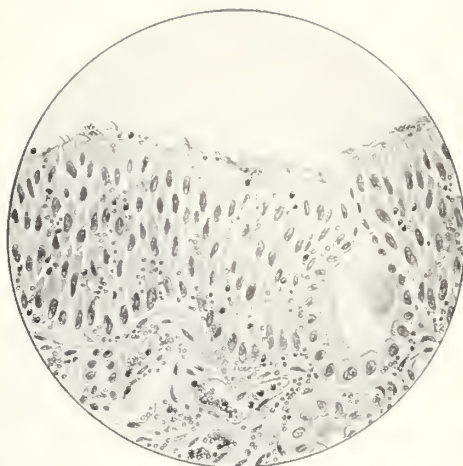
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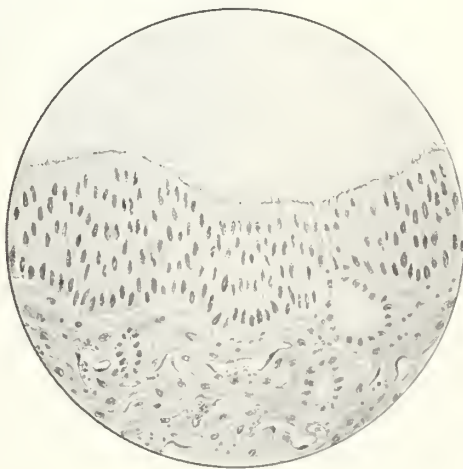
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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

“**H**OW can we provide effective nursing care in tuberculosis sanatoria?” World War II, with its accompanying dislocation in medical and nursing services, focused attention sharply upon the problem of general nursing and tuberculosis nursing in particular. It is time to review these problems in the light of postwar conditions and the circumstances which may be expected to arise in years to come.

EFFECTIVE NURSING CARE FOR THE TUBERCULOUS

Throughout the field of nursing there is a deficit of workers, and nursing needs have increased in spite of lower death rates, longer life expectancies, and a healthier population. The increase in population, with more people in older age groups, the higher standards of living, and the expansion of medical prepayment plans, have swelled the demand for hospital beds.

An acute deficit of nurses exists in the field of tuberculosis which still accounts for more than 5 per cent of all the days spent in hospitals in this country. In 1948 more than five thousand graduate nurses, and almost twice as many non-professional auxiliaries, were employed to care for patients with tuberculosis.

Unfortunately, many hospitals are so badly understaffed that nurses cannot give time to the niceties of care. Tuberculosis, because it is chronic and communicable, is a serious dislocation in the life of a patient. In addition to medical treatment, a patient in a hospital needs to have a sense of being cared for without strain and worry, but today a nurse is often too rushed to give the care which will foster this sense. If the pressure and haste, the mechanization of nursing, can be eliminated, many more young women will wish to enter the profession.

In tuberculosis hospitals the nurse is likely to be even more pressed for time than in general hospitals. The recommended standard for nursing services in tuberculosis hospitals has long

been the following: 3.3 bedside nursing hours per 24 hours per bed-surgical patient; 2.7 bedside nursing hours per bed-medical patient; 1.5 bedside nursing hours per semi-ambulant patient; 0.5 bedside nursing hours per ambulant patient. In practice, almost no tuberculosis hospital has been able to employ enough nurses to meet such a standard.

One source of a nurse's satisfaction in her work has always been the sense of sharing the scientific understanding and confidence of the doctor in the treatment of the patient. The doctor who makes the nurse a member of the medical team, who gives her respect and consideration, who is aware of her contribution, and gives her recognition, helps to make nursing a more attractive profession.

Salary is not the nurse's primary consideration. Yet it should be mentioned that nurses' salaries have not risen in relation to the cost of living, and tuberculosis hospital salaries have not kept pace with gradual increases in salary scale in general hospitals.

A more careful observance of safe techniques in guarding nurses against infection in tuberculosis services will undoubtedly attract more women to this branch of nursing. Before being assigned to a tuberculosis service, a nurse should have a general physical examination, a chest x-ray, and a tuberculin test. Each of these procedures should be repeated at intervals. Many

PERITONITIS: what's the risk?

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authorities also recommend BCG vaccination for non-reactors to tuberculin. But few tuberculosis hospitals give nurses routine pre-employment physical examinations, and some even omit tuberculin tests, although pre-employment x-ray is almost universal.

Nurses assigned to tuberculosis services, after passing a physical examination with a chest x-ray, must be protected on the job. Wherever better care of tuberculous patients has been demonstrated, and better protection for workers has been made easily accessible, it has become easier to recruit and retain personnel.

Improvements in recreation and transportation can also help to increase the inducements of tuberculosis nursing. The trend toward building new tuberculosis wings and hospitals close to general medical facilities will undoubtedly make it possible for additional nurses to enter tuberculosis nursing.

More students will also enter tuberculosis nursing if they receive better instruction and are provided with a safer environment in which to practice. In 1946 only 24 per cent of all schools of nursing offered clinical experience in tuberculosis.

There is an increasing acceptance of minority groups and of men in nursing schools and in the profession. If tuberculosis nursing is made attractive enough, it will draw its share of both sexes and from minority groups.

Up to now there has been almost no systematic analysis of the jobs to be done in a tuberculosis

hospital. The present haphazard job "system," with overlapping duties for graduate nurses, practical nurses, aides and orderlies, leads to inefficiency. *Job analyses are urgently needed.* Every hospital should try to use the talents and training of its workers as efficiently as possible.

What then can be done to increase the number of nurses for tuberculosis nursing services in the United States? As has been pointed out, many positive steps can be taken: increasing job satisfaction, better precautions against infection, better instruction of nurses and auxiliaries in tuberculosis nursing, salary adjustments, better hours, increased employment of members of minority groups, job analyses, better utilization of time.

Although it is not inevitable that nursing care will become better as the number of nurses increases, yet the quantity of nurses is considered one index of the quality of patient care. If our society can provide enough nurses to staff its hospitals adequately, each nurse will strive to give the kind of patient care for which she has dedicated herself to her profession. Tuberculosis hospitals, if they keep pace with developments, will share in the improvement of nursing services everywhere.

Effective Nursing Care for the Tuberculous. Chesley Bush, M.D., Esta H. McNett, R.N., B.S., Lucile Petry, M.A., and Martha B. Naylor, R.N., B.S., *Public Health Reports*, August 5, 1949.



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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street, Indiana

A PRESIDENT'S EYE-VIEW OF THE COUNTIES



For the first time in the history of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, the president has been able to report visits to almost all county groups by the end of November. This is largely due to the councilors who suggested a planned itinerary for the president's visits and to the wonderful cooperation of the counties in following the schedule suggested by the president.

At each meeting your president has been greeted with an enthusiastic welcome by the members and an expression of gratitude for coming early in the year. So many have said that they can proceed with more assurance and knowledge than ever before. It stands to reason that, although the State Auxiliary each year sends out a large volume of mail containing suggestions and instructions, the county members really look to the visit of the state president as a source of impetus to their year's work.

Not only have the early visits proved to be an inspiration to the members and county officers but they have also permitted the president to devote more time and effort to the other business of her office. A constant stream of mail coming in from all sources—national, state, and county—keeps your executive officer very busy, since much of the correspondence requires her personal attention.

Various meetings held in Harrisburg, including meetings of the public relations and legislative committees of the Medical Society to which your president is cordially invited, occupy much of her time. To sandwich in all these, as well as not infrequent speaking engagements and home duties which must be taken care of as in any other doctor's home, requires thoughtful advance planning. It is the feeling of this president that the auxiliary members in all counties are begin-

ning to look upon their executive officer in a true light. They know her as a member just like themselves, doing the job to which they elected her, in addition to all the other jobs which any doctor's wife has every day. She and all the state board members are simply going the extra mile in the year they each serve in their respective offices. Knowledge of that fact and realization of the extra demands upon her time have made for better understanding all over the State, in county after county.

To let you see some of the results of the visiting since the convention in September in Pittsburgh, the following outline has been prepared:

October 4—MONROE and CARBON counties joined for luncheon in Stroudsburg with eighteen members attending. Mrs. R. Frederick Jones, president of Monroe, presided, and Mrs. James J. Dougherty, president of Carbon, brought greetings. Monroe passed a resolution against compulsory health insurance. Both groups were so pleased to meet together that they planned for future joint meetings.

October 5—LACKAWANNA county, with the Carbondale women as hostesses, invited the newly organized WAYNE-PIKE auxiliary to join with them at the Hotel American, Carbondale. Mrs. Robert C. Canivan of Honesdale, president, and six of her members attended and met with more than sixty-five members of the hostess group. Mrs. William J. Barrett, president of Lackawanna, presided. Miss Mary H. Stites, Third District councilor, and Mrs. Frederic B. Davies, a member of the state board, spoke to the auxiliaries.

October 6—SUSQUEHANNA auxiliary president, Mrs. Gordon E. Snyder, arranged a lovely luncheon at the famous Montrose Inn. BRADFORD, WYOMING, and several LUZERNE members attended this meeting. Mrs. Rufus M. Bierly, past state president, Mrs. Navier K. Collmann, Twelfth District councilor, and Mrs. Herman A. Fischer, president of Luzerne, were among the honored guests to welcome the president. Bradford president, Mrs. Axel K. Olsen, and Mrs. Oscar L. Reynolds, president of Wyoming, gave brief messages to the group. Beautiful hand-made ceramic ash trays, with the medical insignia, the guests' initials, and W.A.M.S.S.P. burned in the clay, were treasured mementos provided by the hostess.

October 10—This day was the start of a big week for your president and Mrs. Edward H. Bedrossian, her corresponding secretary (the title is certainly a mis-

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nomer), who acted as chauffeur. The first stop was Green Gables in Lewistown where MIFFLIN county, headed by Mrs. S. Meyer Klein, entertained JUNIATA and the very new PERRY county auxiliary. This county's donation to the Medical Benevolence Fund in place of flowers to the president is one of the fine examples of the change in thought among our women. This group was a combination of two districts, Fifth and Sixth, as well as counties, and the result was most gratifying. These counties have the same problems of a rural area and thus can work side by side to assist each other in many auxiliary projects. Mrs. Penrose H. Shelley, Juniata president, and Mrs. Robert N. Reiner, Perry president, attended, as did the newly elected Fifth District councilor, Mrs. Frank J. Corbett, having driven some ninety miles to get there. Mrs. Ralston O. Gettemy, Sixth District councilor, sent greetings and regrets; she was in New York seeing daughter Margaret off for several years' work in Egypt as a missionary nurse.

LAST CALL!

WHO—All interested auxiliary members, and in particular presidents, presidents-elect, and public relations and legislative chairmen

WHAT—Fourth Annual Conference and School of Instruction, Woman's Auxiliary to The Medical Society of the State of Pennsylvania

WHEN—March 9 and 10, 1950

WHERE—Penn-Harris Hotel, Harrisburg

WHY—For a "bigger and better" Pennsylvania Auxiliary

In the evening Mrs. Bedrossian and your president were the guests of Mrs. Andrew L. Benson, one of the state directors, at dinner in Philipsburg. Other members of the CLEARFIELD county auxiliary were in attendance. Following dinner your president spoke before the local Woman's Club on the subject, "Your Family's Future Health."

October 11—Mrs. Franklin G. Haines opened her lovely home in Warren to the combined ELK-CAMERON and WARREN auxiliary members. A very lovely tea followed the meeting attended by some forty women. Mrs. Arthur J. O'Connor, president of Warren, and Mrs. James W. Minter, president of Elk-Cameron, introduced their members. The enthusiasm of this combined group augured well for future meetings of this type. Provisions for lay groups to hear a speaker on socialized medicine were outlined in the outstanding report of Elk-Cameron, and the interest of Warren women in the possibility of attracting new members was most gratifying.

October 12—ERIE county provided a very different type of visit. Up to this time your president had been for the most part in rural territory, where distances were great between towns and meetings required much time both to plan and to attend. The membership in

this county, however, on the shore of beautiful Lake Erie, is a large urban group and practically centered in one city. Hospitality extended to the visitors was most cordial—from the drive of Mrs. Elmer Hess to a point 12 miles from Erie, to escort us into town in the dark so that we would be on the right road, to the drive along the shore front by the president, Mrs. Ralph M. Tidd, the tour of his clinic by Dr. Hess, and the invitations to dinner and breakfast, some of which we could not accept for lack of enough days. More than fifty members attended the luncheon meeting and Mrs. Tidd presided. This county is represented on the state board by Mrs. Frank J. Theuerkauf, a director.

October 13—Mrs. James E. Hadley, president of VENANGO county, Ninth District, and Mrs. Samuel Gottlieb, president of CRAWFORD county, Eighth District, joined their groups in Titusville for a meeting at which the Titusville members served as hostesses for the day. Luncheon at the Colonel Drake Hotel preceded a very pleasant meeting, and satisfaction with the joint meeting was expressed by all who attended. These two counties are widely scattered too and have many problems in common which cooperation and reciprocity can help them to solve. Plans for speakers to lay groups are in the process of completion here. It is in this type of county that the individual member can serve so well. Too many meetings as a group are not feasible, but public relations through other groups to which the members belong can produce excellent results. Sending speakers to clubs and assisting with poster contests are possibilities in these counties.

October 14—Two districts again joined forces to provide a very pleasant meeting in New Wilmington with MERCER county members headed by Mrs. James F. Elder, as hostesses, and LAWRENCE county members from the Tenth District as guests for the day. Mrs. David C. Young, Lawrence president, introduced our president, Mrs. Bedrossian, and Mrs. Hubert J. Goodrich, Tenth District counselor. Mrs. Mary Harker Jones telegraphed regrets and best wishes to all Eighth District counties because other duties prevented her presence at these meetings. Mrs. Jones can well be proud of her Eighth District family.

October 18—WASHINGTON and GREENE counties entertained at a luncheon at the Nemaquin Country Club, Washington. Mrs. Joseph L. Bryant, Washington president, presided. Guests included our president; Mrs. Howard H. Hamman, president-elect of the State Auxiliary and chairman of organization; Mrs. Joseph E. Shelby, Eleventh District counselor; Mrs. Clinton E. Bane, Greene president acting for Mrs. Wayne E. Booher who was ill at the time; and Mrs. Laurie D. Sargent and Mrs. Charles H. Smith, past state presidents.

October 19—At the Country Club in Uniontown FAYETTE and WESTMORELAND counties held a luncheon meeting. Members from GREENE county unable to attend the Washington meeting came to this one. Attending the Washington and Uniontown meetings were Mrs. Hamman, Mrs. Shelby, Mrs. Bane, and Mrs. Smith. Other guests included Mrs. Albert J. Blair, state director, Mrs. Dan G. Bierer, Westmore-

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land president, Mrs. Lester L. Bartlett, Allegheny president, and Mrs. Hubert J. Goodrich, Tenth District councilor. Mrs. Alfred E. Wright, Jr., Fayette president, presided. The attendance was over fifty. Mr. Robert Stevens entertained with piano selections.

October 20—CAMBRIA county members were hostesses for a joint meeting with SOMERSET, BEDFORD, our newest auxiliary, and INDIANA, at the Sunnehanna Country Club, Johnstown, with sixty-five present. Representing the state board were Mrs. Albert J. Blair of Greensburg, director; Mrs. Albert F. Doyle of Johnstown, legislative chairman; Mrs. Daniel H. Bee of Indiana, publicity chairman; and Mrs. Joseph E. Shelby of Uniontown, Eleventh District councilor. County presidents attending were Mrs. Edward L. Keim, Cambria, who presided; Mrs. John A. Topper, Bedford; Mrs. C. T. Taylor, Somerset; and Mrs. Harry B. Neal, 1948-49 president of Indiana. Mrs. S. A. E. Brallier, Shamokin, a former Cambria president, was also a guest.

October 25—The first rainy day that your president encountered was in Hazleton where she visited the members of that very active BRANCH of LUZERNE county. If the weather was not sunny outside, the warm greetings of the members of this group certainly made up for it on the inside. The president, Mrs. Louis A. Dessen, had arranged for your president to meet her executive board before the luncheon, and the opportunity to assist this auxiliary through this meeting was

appreciated. Mrs. O. Carl Reiche, state *Hygeia* chairman and also national regional *Hygeia* chairman, is a member of this group. Several members of the Luzerne County main auxiliary were on hand, including Mrs. Herman A. Fischer, Jr., the president. Mrs. Patrick J. Gillespie, legislative chairman of the Hazleton group, reported plans for an important meeting with lay groups to hear socialized medicine discussed.

October 26—Mrs. William J. Jacoby, Fourth District councilor, arranged a meeting in Shamokin of all the counties of this district. The meeting was most successful both as to attendance and the interest shown. This district welcomed the newly separated MONTGOMERY and COLUMBIA auxiliaries, which are reporting new members and much enthusiasm for auxiliary work. Hostesses for the day were the Shamokin members, at their Country Club, and presidents from all auxiliaries in the district could well be proud of their groups. Presiding was Mrs. Andrew B. Buczko, president of NORTHUMBERLAND; and, in her position as assistant to the councilor, Mrs. Isadore E. Smigelsky aided in the program. Other members bringing greetings were Mrs. J. William Jones, SCHUYLKILL president, Mrs. William C. Hensyl, COLUMBIA president, Mrs. Edward C. Crowl, MONTGOMERY secretary, and Mrs. Matthew A. Neveretts, SCHUYLKILL BRANCH president. An honored guest of the day was Mrs. E. Roger Samuel, wife of the State Medical Society president.



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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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October 27—Your president with Mrs. Harry W. Buzzerd, Seventh District councilor, journeyed to Coudersport to meet with members from POTTER and TIOGA auxiliaries. Mrs. Alfred F. Domaleski, Potter president-elect, had arranged a very special dinner for the eleven women attending the meeting. A guest was Mrs. Kathryn Dorfeld, this year's recipient of one of the Benjamin Rush awards, who was very much interested in the work of the auxiliary and promised to assist the group in providing summer homes for underprivileged children—a fine piece of public relations work. Mrs. Herman C. Page, past councilor and self-styled great-great-grandmother of Potter County, was present, as was Mrs. Archibald Laird, one of the state vice-presidents. After the meeting Mrs. Buzzerd, Mrs. Domaleski, and your president visited at the home of Mrs. Herman C. Mosch, Potter president, who was unable to attend the meeting, and discussed plans for an open meeting which these women will sponsor in the spring.

October 28—Williamsport Woman's Club was the meeting place for more than thirty women representing CLINTON and LYCOMING counties. Mrs. Amos V. Persing, Lycoming president, introduced the honor guests which included Mrs. David W. Thomas, past national and state president, Mrs. Edward Lyon, past state president, and Mrs. Frank P. Dwyer, state recording secretary and honorary member. This was another successful joint meeting with Mrs. William C. Long, Jr., Clinton president, sharing hostess honors with Mrs. Persing. Again your president expresses gratitude for the cooperation of these counties in making this meeting possible. The distance traveled by the Clinton wom-

en is well known to her, for she drove that road many times last year when on organization trips into northern counties.

November 1—A successful meeting resulted from the combination of HUNTINGDON, CLEARFIELD, CENTRE, and BLAIR auxiliaries at the Altamont Hotel, Altoona. Presidents of the visiting counties, Mrs. Francis S. Mainzer, Huntingdon, and Mrs. Maximo J. Tornatore, Clearfield, brought greetings; Mrs. John Knox Covey, Centre, sent her message through Mrs. Joseph A. Parrish, a former councilor; and Mrs. Joseph M. Stowell, Blair president, presided and introduced Mrs. Ralston O. Gettemy, Sixth District councilor. Mrs. Gettemy had arranged for a very talented musician, 11-year-old Fawn Marie Fox, to entertain with marimba solos during the luncheon and was responsible for the attractive printed programs and menus for the day. Following the meeting she saw to it that your president was rushed to a bus for Brookville that evening where JEFFERSON county young women were meeting to hear Mrs. Hamman tell them how they were needed in the work and to assist them in getting officers elected so that this county could again become active.

November 2—With Mrs. Hamman again as partner, your president went to Kittanning where the NEW KENSINGTON BRANCH of Westmoreland County met with BUTLER and ARMSTRONG counties for a pleasant afternoon. Mrs. Hugh I. Stitt, Armstrong president, introduced Mrs. Robert M. Johnston, New Kensington president, Mrs. Edward C. Lutton, Butler president, Mrs. Robert S. Lucas, Ninth District coun-

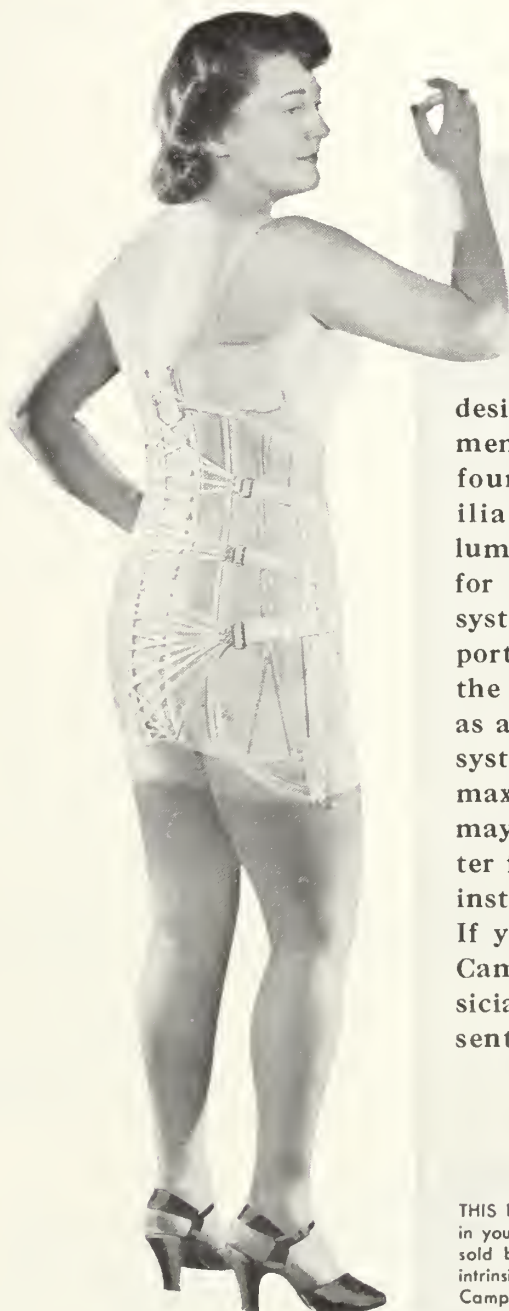
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cilor, Mrs. Hubert J. Goodrich, Tenth District councilor, and Mrs. Lester L. Bartlett, Allegheny president. All had a short message or greeting to bring to the group. Mrs. Frank H. McNutt, Jr., state program chairman, spoke of the collection of sample drugs for the Medical and Surgical Relief Committee.

November 3-4—Mrs. Hamman and your president attended the conference in Chicago for state presidents and presidents-elect, where they gained many new ideas to assist them in promoting auxiliary interest and work in Pennsylvania.

November 8—BUCKS, LEHIGH, and NORTH-AMPTON auxiliaries assembled at the Shrine Club in Allentown with approximately 125 women at the dinner meeting. The tables were lovely with unusual arrangements of fruit surrounded by autumn leaves and pheasant miniatures. Mrs. Lewis J. Leiby, Slatington, gave the invocation and sang Malotte's "The Lord's Prayer," accompanied by Mrs. Carl J. Newhart, Hokendauqua. David Kistler, son of Mrs. Clarke Kistler, auxiliary member, entertained with marimba solos. Mrs. Asher G. Kriebel, Lehigh president, presided. Greetings were extended by Mrs. Walter M. Brenholtz, Northampton president; Mrs. William F. Weisel, Jr., Bucks president; and Mrs. Elmer H. Bausch and Miss Mary H. Stites, councilors of the Second and Third Districts respectively.

November 10—DELAWARE county was hostess at the Llanerch Country Club for CHESTER and MONTGOMERY counties. Mrs. Benedict V. Manis, Chester president, and Mrs. Isaac H. Shelly, Montgomery president, were guests of honor. Mrs. Elmer H. Bausch, Second District councilor, presided.

November 14—YORK county held a luncheon at the Hotel Penn. Mrs. George H. Hoerner, president, pre-

sided and introduced Mrs. Edward H. Bedrossian, state corresponding secretary, and Mrs. Frank J. Corbett, Fifth District councilor, who was hostess to your president and Mrs. Bedrossian on this week's visits. Plans for the successful party given in conjunction with the medical society were discussed; study groups among the nurses and gray ladies in the hospitals were reported; and suggestions for increasing the membership were given. Dr. Phyllis C. Hobbs and Dr. Helen Reardon were interested guests in learning of the work of the auxiliary.

November 15—New ADAMS county members drove to Chambersburg to meet with the FRANKLIN county women. The more than fifty guests at the luncheon included Mrs. Raymond F. Slicely, Adams president, and Mrs. Ray C. Gabler, Franklin president, who presided. Mrs. Corbett introduced her mother, Mrs. Jay W. Yohe. These groups were quite enthusiastic about the joint meeting and felt certain that both would gain much from other meetings of this type.

November 16—LEBANON county entertained at the Country Club and the president, Mrs. F. Allen Rutherford, presided. The program chairman, Mrs. C. Ray Bell, Jr., introduced a talented young pianist, after which your president told the members her message of service to the auxiliary in terms of being big enough for the job that needed doing. Hostesses for the day had arranged an attractive luncheon and more than twenty-five members attended.

That evening Mrs. Bedrossian, Mrs. Corbett, and your president drove to LANCASTER and were guests in the lovely home of Dr. and Mrs. Clarence R. Farmer, where the Lancaster County women were holding their meeting. A report of the convention was given by Mrs. Gilbert N. Clime, the president, who also presided at the



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business meeting. The program included a talk by Mrs. Alice Rubincam, a police woman of the county, who told of her experiences encountered in working with children, their problems, and how she helps to solve some of them. Mrs. Rubincam's message was one to make every mother in the room think twice about the seriousness of the job of training young people today.

November 17—Finishing up this portion of her visits, your president met with more than sixty women representing the hostess county of DAUPHIN and their neighbors, the newly organized CUMBERLAND auxiliary. A program of music, a lovely luncheon, and friendly greetings from Mrs. Kermit L. Leitner, Dauphin president, and Mrs. Joseph L. Green, Cumberland president, made an appropriate ending for almost seven weeks of county visiting.

Your president can safely suggest that counties that did not plan to join with another county for these meetings should definitely consider such an arrangement for another time. The friendships made, the ideas exchanged, and the problems that can be solved by sitting down together and talking with members of another county will do much to make the Auxiliary a very active organization in Pennsylvania.

In January the remainder of the counties will be visited and will be reported on at a later date. Thank you all for the wonderful inspiration that you have given to me to go on my way, doing my part of this huge task with a willingness that comes from a feeling of helpfulness backing me up from all the counties.

(MRS. DRURY) ELIZABETH M. HINTON,
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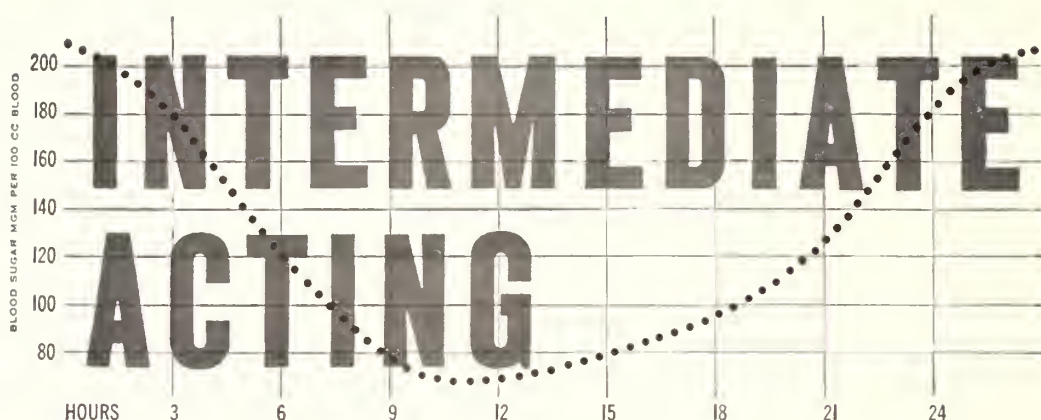
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1. Rohr, J.H., and Colwell. *A.R. Arch. Int. Med.* 82:54, 1948.
2. *ibid Proc. Am. Diabetes Assn.* 8:37, 1948.



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MEDICAL NEWS

Births

TO DR. AND MRS. ARTHUR S. REYNOLDS, of Haver-town, a daughter, December 28.

TO GEORGE HOLLANDER, M.D., AND BEA STERLING HOLLANDER, M.D., of Philadelphia, a daughter, Fredda Sterling Hollander, January 12.

Engagements

MISS JOAN HELENE FELDMAN, of New York City, to Samuel D. Kron, M.D., of Philadelphia.

MISS ANNE BLISS, of Brookline, Mass., to Mr. Robert Bower, son of Dr. and Mrs. John O. Bower, of Wyncote.

MISS CATHERINE EVANS BABCOCK, daughter of Dr. and Mrs. W. Wayne Babcock, of Bala, to Mr. Egil Amlie, of Oslo, Norway.

MISS JEAN LIVINGSTON HOLSCLAW, of Hopewell, Va., to Mr. Richard Thomas Ellison, Jr., son of Dr. and Mrs. Richard T. Ellison, of Philadelphia.

Marriages

MRS. ETHEL M. KENDIG ZIMMERMAN, of Shippensburg, to Asher G. Ruch, M.D., a resident physician at Mont Alto Sanatorium, recently.

MISS RUTH BRECKWOLDT, of Scarsdale, N. Y., to Mr. Frederick Fraley, Jr., son of Dr. and Mrs. Frederick Fraley, of Philadelphia, January 28.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ Edwin G. Hamilton, Warren; University of Pennsylvania School of Medicine, 1919; aged 56; shot and killed himself Jan. 24, 1950. The coroner stated that he was apparently mentally depressed. Dr. Hamilton was a past president of the Warren County Medical Society, and was a Fellow of the American College of Surgeons. Serving in the U. S. Army during World War I, he returned to duty as a naval officer in World War II with the rank of lieutenant commander. Later he was advanced to the rank of full commander. In addition to the Presidential Unit Citation, he held service ribbons for the American, European, African, and Asiatic-Pacific theaters, with numerous service stars, and the World War II Victory ribbon and medal. He is survived by his widow, a daughter, two sons, and two sisters.

○ Homer B. Wilcox, Sr., Kingston; University of Pennsylvania School of Medicine, 1901; aged 72; died Jan. 9, 1950 of a heart ailment. Dr. Wilcox, who was retired, was a member of the American Urological Association and a Fellow of the American College of Surgeons. Surviving are his widow, two daughters,

and a son, Homer B. Wilcox, Jr., M.D., assistant physician in the department of medicine at Germantown Hospital, Philadelphia. A sister also survives.

○ Wilford L. Thunhurst, Wilkinsburg; University of Pittsburgh School of Medicine, 1909; aged 62; died Jan. 5, 1950, after a long illness. Dr. Thunhurst was formerly a staff member of the Pittsburgh Hospital for many years and was prominent as a physician and sportsman. A skillful golfer, he held the course record of 68 for the Edgewood Country Club—a record which still stands. He is survived by his widow, a son, his mother, and a brother.

○ Vincent Marcucci, Philadelphia; Medico-Chirurgical College of Philadelphia, 1915; aged 57; died Jan. 8, 1950, after a short illness. Dr. Marcucci was on the staff of Pennsylvania Hospital. He served in World War I, first in the U. S. Army, then with the Royal Lancaster Guards of the British Army, when he commanded fourteen base hospitals in England. Dr. Marcucci was unmarried and his only immediate survivor is a brother.

○ M. Clayton Thrush, Philadelphia; Medico-Chirurgical College of Philadelphia, 1901; aged 74; died Jan. 17, 1950. Dr. Thrush was also a graduate of the Philadelphia College of Pharmacy and Science and received his doctorate in pharmacy at the University of Buffalo. He practiced medicine for nearly fifty years. During World War I, he served as a major in the Army Medical Corps. His widow and three daughters survive.

Charles P. Major, Philadelphia; University of Pennsylvania School of Medicine, 1907; aged 67; died Jan. 19, 1950. Dr. Major was a pediatrician and had been on the staff of Germantown Hospital since 1912. He was a captain in the Army Medical Corps during World War I, and was wounded in France. Surviving are a son and a sister. His wife died May 30, 1949.

Miscellaneous

MAX M. STRUMIA, M.D., of Bryn Mawr, has been elected president of American Medical Relief for Italy and Pennsylvania, Inc.

MAYER A. GREEN, M.D., of Pittsburgh, presented a paper before the annual meeting of the American College of Allergists in St. Louis, January 18, entitled "Herpes Gestationis."

MARCH 11, 1950, WILL MARK THE ONE HUNDREDTH ANNIVERSARY OF THE FOUNDING OF THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA. A Founders' Day dinner will be held on March 10 as part of the celebration.

THE PHILADELPHIA GENERAL HOSPITAL ANNOUNCES a two-year residency in physical medicine and rehabilita-

tion. This service, approved by the American Board of Physical Medicine, is directed by Albert A. Martucci, M.D.

THE AMERICAN GOITER ASSOCIATION will hold its next meeting in the Shamrock Hotel, Houston, Texas, March 9, 10, and 11. The program for the three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics, and demonstrations.

THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL will hold a five-day seminar in otolaryngology and ophthalmology beginning April 17. Details of the course can be obtained by writing David N. Barrows, M.D., medical executive officer of the school, 341 West Fiftieth St., New York 19, N. Y.

ARCHIBALD G. FLETCHER, JR., M.D., of Philadelphia, recently resigned from the University of Pennsylvania Hospital staff to go to India as a Presbyterian medical missionary. Dr. Fletcher was born in Korea, his parents having been medical missionaries. Mrs. Fletcher's parents also were missionaries.

JOSEPH C. DOANE, M.D., who retired recently as medical director of Jewish Hospital, Philadelphia, after 21 years' service, was honored by the hospital staff at a testimonial dinner in the Warwick Hotel the

evening of January 15. About 300 persons attended. A portrait of Dr. Doane was presented to the hospital by the trustees.

RESIDENT PHYSICIANS OF WILLS EYE HOSPITAL and more than 100 ophthalmologists of the Philadelphia area were addressed by Dr. Charles Safar, professor of ophthalmology at the University of Vienna, the evening of January 23. Dr. Safar spoke on "Electro-surgery of the Eye." He is the inventor of the Safar needle, which incorporates the use of high frequency current for eye surgery.

A PARAPLEGIA FELLOWSHIP FUND has been created at the medical laboratories of the University of Pennsylvania for a new research program to aid crippled war veterans and other paraplegic victims. The fund will be used exclusively for an investigative program for the relief of bedridden and wheel chair paraplegics. Dr. W. W. Chambers, assistant professor of anatomy at the University's School of Medicine, has been selected to head the new project.

BETA CHAPTER OF PHI LAMBDA KAPPA FRATERNITY will present its annual lectureship on Wednesday, March 8, at 8 p.m., in McClellan Hall of Jefferson Medical College, 1025 Walnut Street, Philadelphia. Joe Vincent Meigs, M.D., clinical professor of gynecology, Harvard Medical School, and chief of the Vincent Memorial Hospital, the gynecologic service of the

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Massachusetts General Hospital, Boston, will speak on "Carcinoma of the Cervix."

JOHN P. HUBBARD, M.D., DIRECTOR OF THE STUDY OF CHILD HEALTH SERVICES OF THE AMERICAN ACADEMY OF PEDIATRICS AT CHILDREN'S HOSPITAL, PHILADELPHIA, has been appointed chairman of the Department of Public Health and Preventive Medicine at the University of Pennsylvania School of Medicine. Dr. Hubbard will also be the George S. Pepper professor of public health and preventive medicine at the medical school. He studied public health methods in Europe and Japan as a Rockefeller traveling fellow in pediatrics and public health.

A COMPETITIVE EXAMINATION FOR APPOINTMENT OF medical officers in the Regular Corps of the United States Public Health Service will be held on May 15, 16, and 17, 1950. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than April 17. Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

A THIRD SHEET SUPPLEMENT OF THE U. S. PHARMACOPOEIA XIII has just been released which gives Pharmacopoeia status to several important new items in advance of the appearance of the U.S.P. XIV, which is to be released in a few months.

The new texts are penicillin G sodium and penicillin G potassium, also crystalline vitamin B₁₂ and its injection.

The Third U.S.P. Supplement will be mailed without charge to all who request it. Write to E. Fullerton Cook, U.S.P. Revision Chairman, 4738 Kingessing Ave., Philadelphia 43.

LOUIS COHEN, M.D., OF PHILADELPHIA, has been named clinical professor of medicine at Temple University Medical School to succeed his brother, Dr. Abraham J. Cohen, who died December 30. Dr. Cohen has held the rank of associate professor of medicine at Temple for several years. He is also the chief visit-

ing physician for the tuberculosis department of the Philadelphia General Hospital and the Philadelphia General Hospital for Contagious Diseases. He is chief of the chest department at Montgomery Hospital, Norristown, and chief of the pneumothorax clinic in Norristown for the State.

A POSTGRADUATE ASSEMBLY IN ENDOCRINOLOGY including diabetes sponsored by the Association for the Study of Internal Secretions and the American Diabetes Association will be held at the Roney Plaza Hotel, Miami Beach, Fla., April 3 to 8.

A fee of \$75 will be charged for the entire course and the attendance will be limited to 100. Please forward application on your letterhead together with check payable to the Association for the Study of Internal Secretions, to Henry H. Turner, M.D., Secretary-Treasurer, 1200 North Walker St., Oklahoma City 3, Okla., before March 3. Further information and program will be furnished upon request.

THE FIFTH ANNUAL SERIES OF INTENSIVE POSTGRADUATE COURSES arranged by the George Washington University will be conducted as follows in 1950:

Anesthesiology	February 27-March 3
Pediatrics	March 6-10
Current Trends in Internal Medicine ..	March 13-17
Surgical Physiology	March 20-24
Obstetrics and Gynecology	March 27-31
Psychiatry	April 3-7

Requests for catalogues and other information should be addressed to: The University Hospital, 901 23d St., N.W., Washington 7, D. C.

APPROXIMATELY 300 PEOPLE ATTENDED A DINNER at the Warwick Hotel, Philadelphia, the evening of January 17, to honor Harriet Louise Hartley, M.D., upon her retirement. Dr. Hartley was chief of the division of child hygiene in Philadelphia's Bureau of Health for 34 years. Mayor Samuel, in a message read by Rufus S. Reeves, M.D., director of the Department of Public Health, said that the infant mortality rate, under Dr. Hartley's guidance, has decreased from 107 to 32 out of 1000 births, while the number of diphtheria cases declined from 3887 in 1925 to 16 in 1949. Three thousand children are now getting eye

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GENERAL—Sixty-fifth annual session began September 12, 1949. Catalog and information regarding courses on request. Address all communications to

THE DEAN, THE SCHOOL OF MEDICINE, UNIVERSITY OF PITTSBURGH

care in free clinics established by Dr. Hartley, and 20,000 children are receiving dental treatment, Mayor Samuel added. Dr. Reeves presented Dr. Hartley with a handbag and two pieces of luggage on behalf of the city officials, civic leaders, leading physicians, and nurses who attended.

A SCIENTIFIC PROGRAM AND BANQUET for a surprise commemoration of Dr. Donald Guthrie's forty years as surgeon-in-chief of the Guthrie Clinic and Robert Packer Hospital at Sayre, held on Tuesday, January 10, proved to be a delightful as well as an interesting occasion. At 2:30 p.m. instructive talks were delivered: "Coronary Heart Disease" by William D. Stroud, M.D., professor of cardiology at the Graduate School of Medicine, University of Pennsylvania, and "A Review of Interesting Surgical Cases" by Edgar Burke, M.D., surgeon at the Jersey City Medical Center.

At the same time a bridge party for the ladies was held in the Nurses' Home.

A social hour and dinner preceded the following evening program in the Sayre High School gymnasium, which was presided over by George W. Hawk, M.D.:

Selections by the nurses' chorus.

Introduction of guests.

Guest speaker—Mr. Paul Webb, cartoonist for *Esquire* and *Saturday Evening Post*.

"A Résumé of the Past Forty Years"—Dr. George W. Hawk.

Guests and many others in attendance thoroughly enjoyed the opportunity to pay their respects to Dr. Guthrie, president of The Medical Society of the State of Pennsylvania in 1933, and for more than a decade a member of its Board of Trustees.

During the day Dr. Guthrie was affectionately acclaimed as preceptor, consultant, and surgeon.

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Wanted.—Resident physician, licensed to practice in Pennsylvania, for a small general hospital near Philadelphia. Remuneration and living quarters provided. Address W.M. H. MOORE, Administrator, Memorial Hospital, West Chester, Pa.

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Residents Wanted.—Surgical and medical residencies in 135-bed general hospital, 12 months ending June 30, 1951. Not approved for training, but wealth of experience. Salary \$300 a month and maintenance. Pennsylvania registration required. Write LEWISTOWN HOSPITAL, Lewistown, Pa.

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THE USE OF THE TECHNIQUE OF PROGRESSIVE-RESISTANCE EXERCISE IN ADOLESCENCE

(By J. ROSWELL GALLAGHER, M.D., Andover, and
THOMAS L. DELORME, M.D., Boston, Mass.,
J. Bone & Joint Surg., October, 1949)

In adolescence, such disorders as mechanical derangement of the knee joint, low-back strain, and insufficient development of the arms, shoulders, and chest frequently occur, and suggest the use of therapeutic exercise. Recently a technique has been reported for the development of the muscle power, which gives promise of being of considerable value. The basic principle of this technique—progressive-resistance exercise—is that muscle power is better developed by exercising a muscle a few times at its maximum capacity than by having the muscle repeat an exercise many times against less resistance. Special equipment and methods have been developed to permit the proper application of this principle.

The technique of progressive-resistance exercise has important implications beyond the strictly clinical field for those who deal with adolescents. It relates to that philosophy which in recent years has emphasized the abuse of rest and the need for the development of fitness rather than the avoidance of strain and fatigue; and takes issue with those physical educators who emphasize the social-psychologic objectives of athletics and neglect the development of adequate muscle power and endurance. It is obvious to most of us who deal with adolescents that strength needs to be developed as well as endurance, coordination, flexibility, and skill; and that, if injuries are to be avoided, some games demand considerable strength about the joints. In addition, it is undoubtedly true that most activities will be performed more successfully and with less fatigue when greater strength and endurance are present; the individual will pay less physiologically, and therefore become less fatigued, when he is able to react well below his maximum limit.

The tendency of knee joint injuries to recur is well known, and the need for combating the atrophy and hypotonia of the extensor muscles of the thigh which accompany these injuries is all-important. Whether or not the ligaments are torn, whether the cartilage is damaged or removed, the most important part of the after-care of knee injuries is the development of strength in the quadriceps; frequently too much attention is paid to the lesion in the joint and too little to the subsequent development of power in the supporting muscles. Progressive-resistance exercises can restore the power lost, and can produce a much greater strength in the supporting muscles than they possessed prior to the initial injury. However, we do feel that a knee joint which is free from fluid, has a normal range of motion, shows no atrophy of the thigh muscles, and can be vigorously extended against the examiner's resisting hand is not necessarily ready for skiing, football, or other strenuous activities. These activities can, and do, put sudden and severe strain on the supporting muscles,

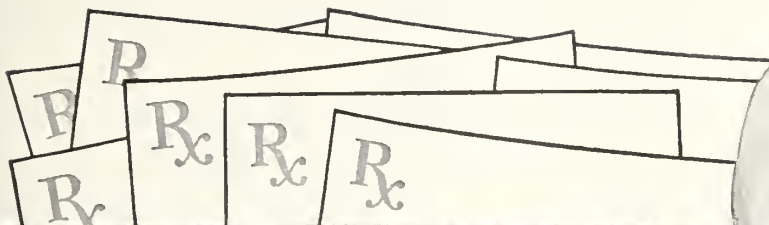
far beyond the limits imposed at an examination. A knee joint is not ready for such stresses until it has extraordinary strength; absence of pathologic signs is not enough.

The relatively rapid loss of cardiovascular-pulmonary endurance after cessation of a training program is well known. The persistence of the weight-resisting ability is obviously much greater; there has been no significant loss in any of these cases.

Symptoms of low-back strain are common in adolescence. During this period of rapid growth and strenuous but poorly coordinated exertion, there is frequently insufficient strength of the low-back muscles to prevent excessive strain being put on the lumbar and sacro-iliac ligaments. More common disorders than postural or ligamentous strain, such as spondylolisthesis and epiphysitis, need be kept in mind; and careful clinical and roentgenographic examinations of even the most transitory low-back symptoms are essential.

Examinations of adolescents which seek ways to improve health and fitness, as well as to uncover abnormalities, will frequently reveal youths whose arms are exceedingly thin, whose chests are flat, and whose shoulder girdles are poorly developed. It would seem reasonable to believe that improvement in these conditions would be beneficial. The youth who does not wish to be bigger or stronger is rare; and, if for no other reason than to satisfy these wishes, it is proper to try to help him. To take the position that brains are all-important and to deny the part that brawn plays in an adolescent's mental health and adjustment is unfortunate. These exercises may be considered more properly a part of a physical education program than the concern of the physician, pediatrician, orthopedic specialist, or physical therapist, but often they can be combined with exercises for the back, knees, or other region which brings the patient in for treatment. Too few physical educators or athletic coaches spend much effort in the improvement of the strength of the less able athletes; many of them are interested chiefly in the development of skill and in the psychologic values of games.

On the basis of this preliminary experience with progressive-resistance exercises in these conditions of adolescence, it seems obvious that the method is a valuable adjunct to other physical therapy procedures. The objective nature of the exercises, the fact that numerical values can be assigned and progress charts kept, and the fact that new and strange equipment is used all contribute to the patient's interest and cooperation. It would appear that the benefits of these procedures persist over a considerable length of time; further study of this point is obviously necessary. More investigation of the nature of the improvement in ability to handle weight is also needed. Factors other than muscle hypertrophy must exist to explain the changes noted. The concomitant improvement in the contralateral limb has not been discussed, but in each of these cases it has been noted, and it has been described by Hellebrant, Parrish, and Houtz.—Abstracted by ALBERT A. MARTELL, M.D., chairman of Commission on Physical Medicine and Rehabilitation of MSSP.



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BOOK REVIEWS

Diseases of the Aorta. By Nathaniel E. Reich, Associate in Medicine, Long Island College of Medicine; Attending Cardiologist, Harbor Hospital, Brooklyn, N. Y. 260 pages, illustrated. New York: The Macmillan Company, 1949. Price, \$7.50.

Dr. William Dock in a foreword points out that the study of this vital blood-carrying tube has been a hobby of the author. Embryology and anatomy are briefly but adequately reviewed. Congenital abnormalities occupy an important chapter, which is well illustrated with drawings and photographs. Other chapters discuss arteriosclerosis, syphilis, the aortic valve, dissecting aneurysm, occlusions, and rarer diseases of the aorta. Two chapters are devoted to diagnostic procedures including roentgenography. Chapters discussing antibiotics and anticoagulants add little to the value of the book and seem to have little place in the subject under discussion.

The book should prove a handy reference, particularly for its illustrations and references when diseases of the aorta are under consideration.

Practical Aspects of Thyroid Disease. By George Crile, Jr., M.D., F.A.C.S., Department of Surgery, Cleveland Clinic. Illustrated. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$6.00.

As its name implies, this volume is designed to present the picture of disease of the thyroid gland in such a way that physicians and surgeons may have at hand a quick reference. Following each chapter there is an excellent bibliography for those who wish more detailed information. The book is well organized; it is divided into 27 chapters, each taking up a specific problem.

The chapter on pathology of endemic goiter includes the classification as adopted by the American Society for the Study of Goiter. The author calls attention to certain weaknesses in this classification, mainly due to the difficulty of determining the presence or absence of nodules in the thyroid before operation. The prevention and treatment of endemic goiter is dealt with in an excellent manner. The author also gives his reasons for the diminishing incidence of goiter in endemic areas at the present time. There is included in this chapter an excellent chart of the evolution and interrelationship of various types of goiter.

The author stresses the importance, and rightly so, of removing intrathoracic goiters through a cervical incision without splitting the sternum. Some surgeons

will probably differ with his handling of the large cavity left after removal of such goiters since he does not drain this space.

The author outlines his experience with the use of radioactive iodine which in his hands appeared to be quite good, but he stated that his experience was quite limited and he felt that this method should be reserved for older patients or those having special complications who might not respond to recognized procedures.

The author's technique of thyroidectomy is illustrated in a splendid manner. He stresses the importance of anatomical dissection, with which, I am sure, all surgeons at the present time will agree. He states his preference for intratracheal anesthesia. The reviewer has never been impressed with the importance of using intratracheal anesthesia except in specific types of goiter, such as intrathoracic goiters or those that have some obstruction to a proper airway, such as injury to the cord or tracheal compression. It is well recognized that there are many postoperative complications, such as laryngeal edema of excessive mucus after routine use of this method, and undoubtedly most thyroid surgeons would reserve intratracheal anesthesia for those cases in which there is special indication.

There is an excellent chapter on carcinoma of the thyroid. This deals with certain discrepancies in reported statistical incidence in various published papers. It reveals the author's experience with malignancy of the thyroid, of which there was an incidence of 3.9 percent in 768 patients subjected to thyroidectomy. He describes the non-encapsulated sclerosing tumors of the thyroid which are frequently called adenocarcinoma. The reviewer is sure that many surgeons have been startled by the return of a pathologic report four or five days after operation stating that a specimen contained an adenocarcinoma of the thyroid. The author also gives an excellent description of the lesions under the classification of thyroiditis, differentiating between Riedel's struma and Hashimoto's disease.

This excellent volume can be highly recommended, particularly to residents, interns, and practicing physicians, as well as to the busy surgeon. It is a welcome addition to any medical library.

The Eye and Its Diseases. Edited by Conrad Berens, M.D., F.A.C.S., Managing Director of The Ophthalmological Foundation, Inc.; President of the Snyder Ophthalmic Foundation, the American Academy of Ophthalmology and Otolaryngology and of the Pan

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American Association of Ophthalmology; Diplomate and former Member of the American Board of Plastic Surgeons; formerly President of the Section on Ophthalmology of the American Medical Association; Fellow of the American Ophthalmological Society, the American Illuminating Engineering Society, and the Aero-Medical Association; Vice-President of the National Society for the Prevention of Blindness and of the International Society for the Prevention of Blindness. Second edition, with 436 illustrations, 8 in color. Philadelphia: W. B. Saunders Company, 1949. Price, \$16.00.

The contents of this text cover the entire field of ophthalmology. There are 76 chapters on the different phases of ophthalmology written by 92 international authorities.

This second edition has some definite improvements over the first edition which came out more than thirteen years ago. Each chapter has been revised or rewritten and brought up to date by including the newer advances in therapeutics and methods of diagnosis. The arrangement of the printed material in a double column on each page makes for easier reading.

This book is recommended to those desiring a complete reference work on the present-day concept of the eye and its diseases.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

From the Hills. An Autobiography of a Pediatrician. By John Zahorsky, M.D. St. Louis: The C. V. Mosby Company, 1949. Price, \$4.00.

Human Growth. The Story of How Life Begins and Goes On. Based on the educational film of the same title. By Lester F. Beck, Ph.D., Associate Professor of Psychology, University of Oregon, with the assistance of Margie Robinson, M.A. New York: Harcourt, Brace & Company, 1949. Price, \$2.00.

Chemotherapy of Leukemia and Leukosarcoma. By William Dameshek, M.D., Marvin L. Bloom, M.D., Louis Weisfuse, M.D., Milton H. Freedman, M.D., Miguel Layrisse, M.D., New England Center Hospital—Tufts College Medical School, Boston, Mass. A reprint of an exhibit presented at the American Medical Association convention, Atlantic City, June, 1949. New York: Grune & Stratton, 1949. Price, \$4.75.

Handbook of Medical Management. By Milton Chatton, A.B., M.D., Instructor in Medicine, University of California Medical School, San Francisco; Sheldon Margen, A.B., M.D., Clinical Instructor in Medicine and Research Associate in Medicine, University of California Medical School, San Francisco; and Henry D. Brainerd, M.D., Assistant Clinical Professor of Med-

icine and Pediatrics, University of California Medical School, San Francisco, Assistant Clinical Professor of Pediatrics, Stanford University School of Medicine, and Physician in Charge, Isolation Division, San Francisco Hospital. First edition. Palo Alto, Calif.: University Medical Publishers, 1949. Price, \$3.00.

Physiology of Heat Regulation and the Science of Clothing. Prepared at the request of the Division of Medical Sciences, National Research Council. Edited by L. H. Newburgh, M.D., Professor of Clinical Investigation, University of Michigan Medical School. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$7.50.

The Physiology of Thought. A functional study of the human mind in action. By Harold Bailey, M.D., F.A.C.S. New York: The William-Frederick Press, 1949. Price, \$3.75.

Essentials of Obstetrical and Gynecological Pathology. By Robert L. Faulkner, M.D., F.A.C.S., Assistant Professor of Gynecology, Western Reserve Medical School; Associate Gynecologist, University Hospitals of Cleveland, Ohio; and Marion Douglass, M.D., formerly Assistant Professor of Gynecology, Western Reserve Medical School. With 300 illustrations, including 3 color plates. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$8.75.

Physiology of the Uterus. By S. R. M. Reynolds, M.A., Ph.D., Staff Member, Physiologist, Department of Embryology, Carnegie Institution of Washington. Baltimore; Lecturer in Obstetrics, Johns Hopkins University School of Medicine, Baltimore. Second edition, revised and enlarged. New York: Paul B. Hoeber, Inc., 1949. Price, \$12.50.

Diagnosis and Treatment of Brain Tumors and Care of the Neurosurgical Patient. By Ernest Sachs, M.D., Research Associate in Physiology, Yale University, New Haven; formerly Professor of Clinical Neurological Surgery, Washington University School of Medicine, St. Louis. 348 illustrations and 10 color plates. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$15.00.

" . . . Over the head of the farmer hangs a threat perhaps more serious than that applied to the worker. The farmers are paid heavy subsidies to produce more food, but there is a regular inspection of every farm and a record kept of its produce. If the farmer falls short of the kind of job expected of him in following the instructions from London, he gets a warning, and if he does not mend his ways the government will walk in, put a price upon his property, pay him for it, and put him off the farm, which then passes into the hands of a government manager."—JOHN T. FLYNN, *The Road Ahead*.

PENNSYLVANIA TUBERCULOSIS AND HEALTH SOCIETY

The name of the Pennsylvania Tuberculosis Society has been changed to the Pennsylvania Tuberculosis and Health Society.

The aim of the society is "preventing and controlling tuberculosis and promoting adequate and effective public health service generally throughout the Commonwealth of Pennsylvania by education, demonstration, cooperation, guidance and such other methods as the society may adopt."

This is the second change of name since the society, the oldest voluntary citizen tuberculosis organization in the United States, was formed in 1892 by Dr. Lawrence F. Flick as the Pennsylvania Society for the Prevention of Tuberculosis. In 1920 that name was changed to the Pennsylvania Tuberculosis Society.

"The voluntary tuberculosis organizations have to a steadily increasing extent been devoting effort to assisting in public health services other than tuberculosis control," said Arthur M. Dewees, executive secretary. "It is believed that the Pennsylvania Society is keeping faith with the founders in looking forward, and even at present participating in, a broader field of public health service while continuing to be of all possible help in the task of conquering tuberculosis, which is still a serious public health problem."

training opportunities too much during the first three years. However, the board does not accept a fourth year, or more, of residency training as a substitute for any part of the required two years of post-training practice.

The importance of post-training practice in the specialty is emphasized as an opportunity for maturing of the candidate and for colleague appraisal of a man's ability when working on his own responsibility in his chosen community. The only exception to this ruling is in the case of men advancing from their training into full-time teaching positions. These men then must complete at least two years in such positions.

Copies of the *Bulletin* of this board, outlining the above requirements in more detail, are available to hospital administrators or to candidates upon application to the secretary, PAUL TITUS, M.D., 1015 Highland Building, Pittsburgh 6, Pa.

MR. STASSEN REPORTS

The article "Never! Never! Never!" by Harold E. Stassen, president of the University of Pennsylvania, is "must" reading for all physicians and their friends. It appears in the January, 1950 issue of the *Reader's Digest*, page 25. (Series continued in February and March issues.)

It is quite curious to note that recently Mr. Oscar Ewing, after spending approximately seventy-two hours on the British Isles, was unable to give a complete and complex report on this system immediately to his perfect satisfaction and to the consternation of some who are serious open-minded individuals.

By way of beautiful contrast is the dignified, apparently sincere investigation by Mr. Stassen. Mr. Stassen's comments apparently come after prolonged and serious investigation. Even Mr. Stassen himself has been frequently classified as a definite liberal, but he states and emphasizes now that it is his considered opinion that *the British program of national health has resulted in more medical care of a lower quality for more people at higher cost.*

To further quote from his article, he has quoted a general practitioner in an English industrial town: "Please tell our friends in America, never, never, never adopt such a program!"—Fact-Finding Committee Report, *Jackson County (Mo.) Medical Society Bulletin*.

RESIDENCY TRAINING REQUIREMENTS

The American Board of Obstetrics and Gynecology has not made nor is it contemplating any changes in its residency training requirements, despite rumors of an increase in training years. Eligibility requirements remain the same, namely, three years of acceptable formal training, followed by at least two years of post-training practice in the specialty.

Hospitals are inspected and approved for training jointly by the Council on Medical Education and Hospitals of the American Medical Association and this board. Approvals are granted for training periods of one, two, and three years depending on the available facilities and the findings of the survey inspections.

This board has no objection to residency services being arranged by hospitals for periods longer than three years, unless this dilutes the candidate's clinical

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Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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mixed
infections



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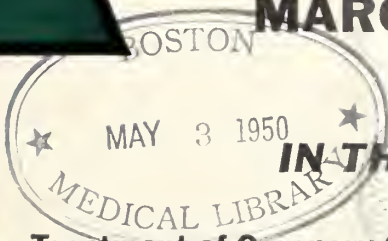
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Hamblen, E. C.: Some Aspects
of Sex Endocrinology
in General Practice,
North Carolina M. J.
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EDGAR I. STEINBERG, M.D.,
Philadelphia, Pa.

GENTLEMEN:

The January, 1950 issue of your JOURNAL has just been received and I immediately noticed its new face.

As one small voice, permit me to say that I think the change is all for the better. The use of the keystone is appropriate, naturally, and the whole cover bespeaks neatness, which is something I am afraid I could not have said about the covers on the previous issues.

JOHN F. WORMAN, Executive Secretary,
Hospital Association of Pennsylvania.

GENTLEMEN:

You asked for suggestions. May I tell you that the JOURNAL is a poor reference volume. The title of the papers should be shown at the top of each page.

J. FRANK ROWLES, M.D.,
Mahaffey, Pa.

GENTLEMEN:

As one who has just been through the same problem, may I congratulate you on the splendid new format and cover of the PENNSYLVANIA MEDICAL JOURNAL which add so much to its appearance and readability.

The changes that have been incorporated continue to maintain the high standards of the JOURNAL and the goal of greater service to your readers expressed in the editorial appearing in the current issue.

ROBERT D. POTTER, Editor,
New York Medicine.

Panama Needs Doctors

GENTLEMEN:

The Panama Canal needs civilian physicians for duty in the Canal Zone. This need has arisen because the Army is withdrawing a large number of commissioned medical officers who have been assigned to duty with the Panama Canal.

This is an unusual opportunity to gain valuable professional experience in a tropical country based on a wide variety of clinical material. There are many opportunities in the hospital service as specialist in pediatrics, general surgery, obstetrics, roentgenology, psychiatry, internal medicine, cardiology, tuberculosis, thoracic surgery, orthopedics, urology, and anesthesiology.

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(Continued on page 206.)



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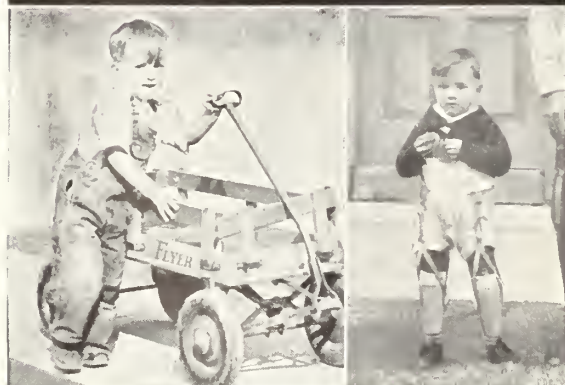
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These positions are on the medical staffs of the Panama Canal hospitals and in outpatient clinics. Starting salaries range from \$6,750 a year to \$9,500 a year, according to training and experience and type of position.

Any persons who might be interested in such employment should apply immediately by completing and forwarding to me Standard Form 57, Application for Federal Employment, copies of which are available at any post office.

B. F. BURDICK, Chief of Office,
The Panama Canal,
Washington 25, D. C.

RESEARCH TO AID PARAPLEGIC VICTIMS

A new research program in aid of crippled war veterans and other paraplegic victims suffering paralysis of the legs and lower portion of the body has been instituted in medical laboratories of the University of Pennsylvania.

From Evansville, Indiana, has come a check for \$1,000 to be used as the nucleus of a fund with which to set up the framework of an investigative program to be devoted exclusively to relief of the bedridden and wheelchair paraplegics. The donors include members of the organization known as American War Dads, the Midwest Paraplegic Veterans, and citizens of Evansville. The War Dads comprise in their membership fathers of crippled war veterans who seek relief of their sons' infirmities.

With the gift, it is stipulated by the donors that the grant is to be known as the Paraplegia Fellowship Fund and the money is to be spent exclusively for research in regeneration of the spinal cord. It is expected the initial grant from Evansville will be supplemented shortly by further benefactions from other sources with which to build up the paraplegic foundation here.

As the result of recent animal experimentations in research laboratories of the University of Pennsylvania, there is hopeful expectancy that ways and means may eventually be found for putting many helpless paraplegics back on their feet through regeneration of their maimed spinal columns.

It was announced that Dr. W. W. Chambers, assistant professor of anatomy in the University of Pennsylvania School of Medicine, has been nominated to head up the new project in spinal regeneration made possible by the Evansville grant.

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The Use and Impact of Antibiotic Therapy

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Baltimore, Md.

SEVERAL months ago, when I received the invitation from your society to deliver the Nathaniel Bedford Lecture, my first thoughts were: Who was Dr. Bedford and what constituted the content of the practice of medicine in Pittsburgh and western Pennsylvania in pioneer times? So, I plan initially to discuss the prevalence of disease and its consequences in Dr. Bedford's era as contrasted with that which we, as physicians, are facing in the present era.

It would appear that Dr. Bedford, who was a distinguished physician in Pittsburgh's frontier days, arrived at Fort Pitt as a military surgeon in about 1765. This was not long after the termination of the French and Indian wars, in the course of which, and at Fort Pitt, disease was first employed as a deliberately conceived weapon of warfare. I wonder how many of my auditors realize that the first (and probably most successful) use of biological warfare was initiated a few hundred yards from where we are gathered tonight. In 1761 or 1762, the confederation of Indian tribes under the leadership of the great Indian organizer and strategist, Pontiac, were again being incited by the French to action against the settlements and garrisons of the Royal Americans west of the Alleghenies. Lord Jeffrey Amherst ("a soldier of the King"), the chief of the Royal American Forces, plagued with the difficulties which confronted him in the maintenance

of so far flung a frontier and with but a handful of troops, in a postscript to a letter written by him to Bouquet at Fort Pitt suggested that an epidemic of smallpox be started among the hostile Mingoe and Delaware Indians. In his reply to Lord Jeffrey ("He fought with all the Indians that came within his sight"), and again in a postscript, Bouquet replied, "I will try to inoculate—with some blankets that may fall into their hands and take care not to get the disease myself." As smallpox was present in Fort Pitt, this was not difficult to do. In his comment on Bouquet's plan, Lord Jeffrey wrote, "You will do well to try to inoculate the Indians by means of blankets as well as to try every other method that can serve to extirpate this exorable race." That this plan was well conceived and tactfully sound is indicated from the following excerpt from the diary of a Captain Ecuyer of the Royal American Forces at Fort Pitt dated June 24, 1762: "Out of our regard for them (the Indians), we gave them two blankets and a handkerchief out of the smallpox hospital. I hope it will have the desired effect." The results probably exceeded Lord Jeffrey's ("and he looked around for more when he was through") best expectations, because within a short time smallpox was sweeping through the Ohio tribes in an epidemic which persisted for more than a year.¹ It appears that one of the major factors which led the French to terminate this war and subsequently cede Canada to Great Britain was the failure of their western

The Nathaniel Bedford Lecture presented before the Allegheny County Medical Society in Pittsburgh on Jan. 17, 1950.

Indian allies to take the offensive in 1762. This story indicates that there can be little doubting the fact that smallpox was an important disease in the Fort Pitt area when Dr. Bedford arrived there three years later.

What other diseases were extant with which Dr. Bedford had to cope? In that extraordinary book on the "Principle Diseases of the Interior Valley of North America" written by that stormy and omnivorous observer, Dr. Daniel Drake, we not only can find an excellent account of disease in western Pennsylvania but also extensive descriptions of its geography, climate, and people in the early part of the nineteenth century. Indeed in this age in which we hear so much about the need for recognizing the social aspects of disease, and when certain zealots are "discovering social medicine," it is refreshing to

find that Daniel Drake more than a hundred years ago devoted Part III of his book to a discussion of the "Physiological and Social Etiology of Disease." Drake has left an admirable description of his survey of the health conditions of Pittsburgh and the surrounding towns. He states that "all the physicians of Pittsburgh and Alleghenytown with whom I conversed agree in representing that the intermittent fevers of this locality may be traced to the low grounds and the swamps to the west and northwest, being more frequent near them, in proportion to the population and diminishing as we receded from them—remittent fever prevails over the same tract—and also beyond; for it occurs in Pittsburgh where intermittents are now nearly unknown, and, indeed, seem never to have prevailed to much extent."

TABLE I
PRESENT-DAY USAGE OF ANTIBIOTICS IN INFECTIONS

<i>Type of Infection</i>	<i>Penicillin</i>	<i>Streptomycin</i>	<i>Aurcomycin</i>	<i>Chloromycetin</i>
Streptococcal infections				
Beta hemolytic	I	II	II	III
Alpha hemolytic	I	II	II	
Non-hemolytic	I		II	
All enterococci	II		I	
Staphylococcal infections	I		I	
Pneumococcal infections	I	III	II	III
Neisserian infections				
<i>N. meningitidis</i>	I		II	
<i>N. gonorrhoeae</i>	I	II	III	III
Diphtheritic infections	I + antitoxin			
Tuberculous infections		I + PAS		
Anthrax infections	I		I	
Clostridial infections				
Gas gangrene	I			
Tetanus	?			
Enteric infections				
<i>E. coli</i>		II	I	I
<i>K. pneumoniae</i>		II	I	I
<i>Proteus</i>		I		

I—first choice. II—second choice. III—third choice. Blank—little value.

While it is beyond the scope of my subject, I cannot help referring briefly to what Daniel Drake had to say about the "factitious atmosphere" which he noted over Pittsburgh. His remarks are especially apropos when one considers the remarkable progress which has been made in smoke control in this city during the past few years. At the time of Drake's survey of Pittsburgh about 10,000,000 bushels of soft coal were being burned annually. He states: "As yet very little of the smoke arising from these fires is consumed, and consequently it escapes in immense volumes, carrying into the atmosphere its carbonaceous matter, carbonic acid, carburetted hydrogen and perhaps sulphurous acid, from the obstacles to free ventilation, which the surrounding hills oppose." Hardly a better description of "smog" has ever been written.

We must note that Drake was especially interested in "intermittent" and "remittent" fevers when he was in Pittsburgh, and indeed for that matter wherever he was in the "Interior Valley." To have knowledge of what concerned Dr. Bed-

ford in his practice, we must consider briefly the "intermittents" and "remittents." As Drake himself states or infers, malaria was rife from the Gulf to Canada in those days, and, because of his observations of the relation of "fevers" to the lowlands and swamps of Pittsburgh, we can conclude that Dr. Bedford saw much malaria. We know that diphtheria (malignant croup), scarlet fever, pneumonia, and meningitis (spotted fever) took their toll. Tuberculosis (consumption) was common, and Drake speaks often of typhoid fever (typhus abdominalis). Cholera, the panic-producing disease, probably did not enter the country until about 1832, so its outbreaks, which produced so much fear later on, were not a problem for Dr. Bedford. Jaundice (epidemic hepatitis) appeared to be common, and of course yellow fever was well known in the Interior Valley.

On top of the practically unrestrained spread of communicable diseases, Dr. Bedford had to face the fact that many of his patients were poorly nourished and suffering from chronic fatigue

TABLE II
PRESENT-DAY USAGE OF ANTIBIOTICS IN INFECTIONS

Type of Infection	Penicillin	Streptomycin	Aurcomycin	Chloromycetin
Salmonella infections				
S. typhosa			II	I
Others		?	?	?
Shigella infections			I	I
Pasteurella infections				
Past. pestis		I + S.D.	U	U
Past. tularensis			I	I
Brucella infections				
Br. melitensis		II + S.D.	I	I
Br. suis		II + S.D.	I	I
Br. abortus		II + S.D.	I	I
Listerella infections			I	U
Cholera			U	U
Hemophilic infections				
H. influenzae meningitis		III + S.D.	I + S.D.	II + S.D.
H. pertussis		II	I	I
H. ducreyi		II	I	I

I—first choice. II—second choice. III—third choice. Blank—little value. S.D.—plus Alfad. zinc. U—unknown.

TABLE III
PRESENT-DAY USAGE OF ANTIBIOTICS IN INFECTIONS

<i>Type of Infection</i>	<i>Penicillin</i>	<i>Streptomycin</i>	<i>Aurcomycin</i>	<i>Chloromycetin</i>
Spirochetal infections				
T. pallidum	I		II	II
T. pertenue	I		U	U
T. carateum	I		U	U
B. recurrentis	I		U	U
B. vincentii	I		U	U
L. icterohaemorrhagiae	?		U	U
Bartonella infections			U	I
Streptobacillary infections		I	U	U
Bacteroidosis		II	I	U
Rickettsial infections				
R. prowazeki			I	I
R. mooseri			I	I
D. rickettsi			I	I
D. conori			I	I
R. akari			I	I
R. tsutsugamushi			I	I
C. burneti			I	I

I—first choice. II—second choice. III—third choice. Blank—little value. U—unknown.

and ill health. The "Interior Valley" was a cruel taskmaster to those who sought to conquer it; life was hard and life was short. While no over-all accurate figures are available, it is safe to assume that the average span of life among Dr. Bedford's patients was about thirty years, so we can be reasonably certain that most of his practice and his interest were centered upon the treatment of infections and accidents, as well as obstetrical cases, because the initial stages of the conquest of the Interior Valley were achieved because efforts in the generation of life outstripped the forces of death. It is unlikely that patients with heart disease, hypertension, cerebral accidents, or cancer were prominent in the practice of Dr. Bedford.

Without an attempt in transition to discuss what has happened since Dr. Bedford's time, I would like to turn to what is going on in the practice of medicine in the present. In 1948 the crude

mortality rate in the United States was 9.9, the maternal mortality rate 2.8 per 100,000, and the infant mortality rate reached a new low. In many of the infectious and communicable diseases new all-time lows for deaths were established. A most striking example of this situation was high-lighted by the fact that but 68 persons were registered as dying of scarlet fever in 1948. There are many of us who can remember the time when scarlet fever was considered a very serious disease.

What has brought about this great change since Dr. Bedford's day? While time does not permit a detailed discussion of the factors involved, one can list the following: (1) improvements in environmental and economic conditions, (2) advances in sanitation, (3) the development of a system of public health, (4) improvements in nutrition, and (5) extraordinary advances in treatment of infections and communicable dis-

eases. It is about one phase in the last of these factors, namely, the use of antibiotics in the prevention and treatment of infections, which I want to discuss tonight.

General Statement

The field of antibiotics is dynamic. Within the past eighteen months we have witnessed the therapeutic control of a number of infectious processes for which, previously, we as physicians could do little but make the patient comfortable and hope that he would get well. New antibiotics have been introduced which have broad areas of activity against the rickettsia, most bacteria, certain of the viruses, and even against at least one of the protozoa. New preparations and new dos-

age forms of the older antibiotics, such as penicillin and streptomycin, have been devised which make their use easier for the physician, less costly, and more pleasant for the patient. Physicians, biologists, and pharmaceutical manufacturers in this country can point with pride to the fact that, with the exception of a very few types of bacterial infections and a few of the viral diseases, highly effective antibiotics are available for the treatment of infectious processes; and that, with the exception of tuberculosis, the infectious diseases which as yet have not been brought under therapeutic control are unimportant in producing death in these United States. But with this rapid progress has come confusion. Where formerly there were but two major antibiotics with two or

TABLE IV
PRESENT-DAY USAGE OF ANTIBIOTICS IN INFECTIONS

Type of Infection	Penicillin	Streptomycin	Aureomycin	Chloromycetin
Viral infections				
Psittacosis	II + S.D.		I	I
L. venereum	II + S.D.		I	I
Primary atypical pneumonia			I	I
Herpes simplex			?	U
Herpes zoster			I	I
Chickenpox			U	U
Vaccinia disseminata			I	U
Smallpox			U	U
Measles			U	U
Mumps				
Infectious mononucleosis				
Epidemic hepatitis			U	U
Epidemic keratoconjunctivitis			?	U
Poliomyelitis				
Influenza				
Common cold				
Parasitic infections				
Acute amebic dysentery			I	U
Fungal infections				
Actinomycosis	I + S.D.		U	U

I—first choice. II—second choice. III—third choice. Blank—little value. U—unknown. S.D.—sulfadiazine.

three dosage forms for each, now there are four which have been released for sale by the Food and Drug Administration and most of them are available as several preparations and in multiple dosage forms. It is therefore obvious that the physician, when confronted with an infectious process which will respond to any one of the several antibiotics, must possess that knowledge which will permit him to select wisely so that his patient will obtain the most effective and least costly type of therapy.

The Antibiotic of Choice

With these points in mind, data are presented in Tables I-V in respect to the choice of antibiotics for use in the treatment of a wide variety of infections. The recommendations contained in these tables are current and are liable to change as experience in the use of the newer antibiotics becomes greater, or when more effective antibiotics are developed. Even so, there are certain fundamental rules which the physician should bear in mind when contemplating the use of antibiotics in the treatment of an infectious process.

1. Adequate doses of the antibiotic should be employed. The aim should be to bring the infection under control as promptly as is possible. This is especially important in the treatment of severe or fulminating infections.

2. Do not overtreat the patient. Antibiotics are often expensive and all of them have potentialities for producing toxic reactions. Watch carefully the clinical and laboratory response of the infection to therapy, and discontinue treatment when in your opinion the infection is controlled.

3. Remember that in most instances the response to antibiotic therapy should be prompt. As a rule, if definite clinical improvement is not evident within two to four days, the physician should question the value of further therapy with the particular antibiotic which he may be using in any given patient. Necessarily this last statement must be qualified by a knowledge of the pathologic nature of the infection. Infectious processes of soft tissues which are of short duration generally clear up promptly, while those in bone, in thrombi, and in certain other tissues require a more prolonged exposure to the antibiotic agent. It is also important in this respect to know whether the antibiotic exerts a *bactericidal* or *bacteriostatic* effect against the causative agent of the infection. If the action exerted is bactericidal, the therapeutic response is generally very prompt; if it is bacteriostatic, the response may be slower and treatment must be more prolonged. And lastly, in this particular consideration, thought must be given to the phenomena

TABLE V
SUGGESTED COMBINATIONS OF ANTIBIOTICS IN SEVERE INFECTIONS

<i>Type of Infection</i>	<i>Penicillin</i>	<i>Streptomycin</i>	<i>Aureomycin</i>	<i>Chloromycetin</i>
Severe staphylococcal	I		I	
Subacute bacterial endocarditis				
Alpha streptococcal	I		I	
Enterococcal	I	I	I	
Gram-negative		I	I	I
Staphylococcal	I		I	
Acute bacterial endocarditis				
Beta streptococcal	I		I	
Pneumococcal	I		I	
Meningitis				
Pneumococcal	I		I	
Staphylococcal	I		I	
Gram-negative		I	I	I

TABLE VI
THE PROPHYLAXIS OF INFECTIONS WITH ANTIBIOTICS

<i>Infection or Condition</i>	<i>Penicillin G</i>	<i>Streptomycin</i>	<i>Aureomycin</i>	<i>Chloromycetin</i>
Cholera			U	U
Gonorrhea	I	U	U	U
Syphilis	I			
Hemolytic streptococcal infection	I		II	U
Meningococcal meningitis	I		U	U
Puerperal sepsis	II		I	U
Rheumatic fever	I		U	U
Subacute bacterial endocarditis	I		II	U
"Clean" surgery	I		I	U
Colonic surgery		II + S.S.	I	U
Pulmonary surgery	II		I	U
Established surgical infections	I°	I°	I°	I°
Extraction of teeth	I	U	II	U

I—first choice. II—second choice. U—unknown. S.S.—sulfasuxidine. °—as indicated. Blank—little value.

associated with a natural recovery from the particular infectious process, especially in relation to immune responses. When certain infectious diseases are treated very early in their evolution and therapy is discontinued as soon as a good response to treatment has been obtained, a prompt relapse may occur due to the fact that immunity has not developed.

4. While the infecting micro-organisms may develop step-like resistance frequently and often quickly to streptomycin, and less frequently to penicillin, this phenomenon appears to be uncommon when either aureomycin or chloramphenicol is being used as the therapeutic agent.

5. In severe or fulminating infections, if two or more effective antibiotics are available, use them simultaneously in the treatment of the patient. The aim of all antibiotic therapy is to bring the infection under therapeutic control as promptly as possible.

6. *Don't give antibiotics "on a hunch that they might do some good."* Use them only when there are indications that their administration is a rational procedure. Only too many times antibiotics are employed without any logic for their use. This practice increases the cost of medical care to

the patient, increases his chance of becoming sensitized to the antibiotic, and does no one good.

Prophylactic Use of Antibiotics

As the range of effectiveness of antibiotics against infections has been increased due to the discovery of new agents, so too have the uses of antibiotics in the prophylaxis of infections. These uses are portrayed in Table VI. Of especial interest are the following: The administration of 300,000 units of crystalline penicillin G by mouth, or of 300,000 units of procaine penicillin G by the intramuscular route will markedly decrease the incidence of gonorrhea in those individuals who are exposed to the chance of this infection. The prompt administration of 600,000 units of procaine penicillin G in oil with 2 per cent aluminum monostearate added will decrease the incidence of syphilis in those who have been exposed to this infection. In closed communities, crystalline penicillin G given by mouth can be used in the prevention of Beta hemolytic streptococcal or meningococcal infections. Aureomycin given by mouth in doses of 2 grams a day for three days appears to be highly effective in the prophylaxis of puerperal infection. The ad-

ministration of procaine penicillin G by the intramuscular route prior to and after the extraction of teeth, the removal of tonsils, or for that matter any operative procedure around the nose or throat in rheumatic subjects, will materially aid in preventing the development of subacute bacterial endocarditis.

There are a certain number of surgical procedures such as cataract operations, etc., which are classed as "clean" operations but subsequent to which infection may develop. Infection after these operations may be materially decreased by prophylactic antibiotic therapy. In operations upon the colon, or in patients with perforating abdominal wounds, the prophylactic use of antibiotics either alone or in combination with certain sulfonamides will markedly decrease postoperative infection. The same is also true in respect to pulmonic operative procedures. In established infections, in which surgical interference is indicated, the proper use of antibiotics will greatly facilitate the control of postoperative spread of the infection. There can be little doubting that the intelligent use of antibiotics has been an important factor in bettering the prognosis of many surgical procedures over the past few years.

Dosage

Not much time will be spent discussing dosages or the various preparations of the antibiotics. These are well described in the package inserts which accompany those antibiotics which have been approved by the Council on Pharmacy and Chemistry of the American Medical Association. There are a few points, however, that are

worth discussing. Since the introduction of procaine penicillin G, the use of crystalline penicillin G can be reserved for the treatment of severe infections. When employed, it should be given in doses of 25,000 units and upwards by the intramuscular route, at intervals of three hours day and night, until the infection is controlled. Among the procaine penicillins, the preparation of 300,000 units of procaine penicillin G which has 100,000 units of crystalline penicillin G added to it is one of the most valuable. This may be given by the intramuscular route in aqueous suspension at intervals of 8 to 12 hours. It combines the features of both continuous and intermittent therapy and is a good preparation to use in selected severe and almost all moderate instances of infection which are susceptible to the antibacterial effects of penicillin. It also produces relatively few reactions.

Another good preparation of procaine penicillin G is that in vegetable oil with 2 per cent aluminum monostearate added. The usual dose given by the intramuscular route is 300,000 to 600,000 units. As the release of the penicillin in the tissues is greatly slowed, detectable (but not necessarily therapeutic) levels of penicillin are found in the blood for about 72 hours after the administration of a single dose. This preparation can be used in the prophylaxis of certain infections and in the treatment of mild and certain moderately severe infections which are susceptible to the effects of penicillin. As a rule, in infections other than syphilis, procaine penicillin G in oil with aluminum monostearate added may be given by the intramuscular route at intervals

TABLE VII
DOSAGE SCHEDULES FOR AUREOMYCIN AND CHLOROMYCETIN

<i>Severity of Illness</i>	<i>Aureomycin</i>		<i>Chloromycetin</i>	
	<i>Initial Dose Mg./Kg. Body Wt.</i>	<i>Total Daily Maintenance Dose Mg./Kg. Body Wt.</i>	<i>Initial Dose Mg./Kg. Body Wt.</i>	<i>Total Daily Maintenance Dose Mg./Kg. Body Wt.</i>
Moderate—oral route	None	20-30	60	60
Severe—intravenous route*	10	25-40		
Severe—oral route	10	50	60	60-120

When the oral route of administration is being used, the calculated total daily maintenance dose is divided into 4 or 3 parts and is given at intervals of 6 or 8 hours.

* When aureomycin is being administered by the intravenous route, do not give more than 300 milligrams in any single dose. The intravenous doses should be spaced at intervals of 6 to 8 hours. A shift should be made to treatment by the oral route as soon as such is feasible.

of 48 to 60 hours. The use of penicillin by mouth for the treatment of systemic infections is not recommended. It is the least desirable and most expensive way of administering penicillin.

At present, it is believed that dihydrostreptomycin offers no special advantages over streptomycin in the doses in which these compounds are now used, and it is definitely more expensive than is streptomycin. The amounts of either of these antibiotics which are currently used for the treatment of susceptible infectious diseases are much lower than formerly. In the treatment of tuberculosis other than miliary and/or meningeal, the recommended dose is now 0.5 gram of either compound administered by the intramuscular route at intervals of 12 hours for at least 42 days. In miliary or meningeal tuberculosis, 0.75 gram of the antibiotics is given at intervals of 12 hours for 90 to 120 days. It is currently considered advisable to use para-amino-salicylic acid in conjunction with streptomycin in tuberculosis. In adults the daily dose of PAS is about 12 grams per day. In infections other than tuberculosis it is rarely necessary to exceed a total daily dose of 2.4 grams of streptomycin or of dihydrostreptomycin. Either of these antibiotics may be given by the intraspinal route.

As will be noted in Table VII, dosage schedules for aureomycin and chloramphenicol (chlor-

omycetin) are fairly well established. For the former, in severely ill patients treated by the oral route, the initial dose should be based on 10 milligrams per kilogram of body weight. The total daily maintenance dose of aureomycin when administered by mouth to moderately ill patients is 20 to 30 milligrams, and for seriously ill patients, 50 milligrams per kilogram of body weight. In either instance the total daily maintenance dose is divided into four parts, one of which is given every six hours. If it seems desirable in seriously ill patients to initiate treatment by giving aureomycin by the intravenous route, the special preparation of the antibiotic for this purpose dissolved in a leucine diluent may be used. The initial dose should be based on 10 milligrams per kilogram of body weight, while the total daily maintenance dose for intravenous use is based upon 25 to 40 milligrams per kilogram of body weight. The latter is divided into thirds, one of which is given every eight hours. In no instance is it believed desirable to administer more than 300 milligrams of aureomycin in one dose by the intravenous route.

With chloramphenicol, the initial dose is based upon 60 milligrams per kilogram of body weight. This is divided into thirds, one of which is given at hourly intervals by mouth. The total daily maintenance dose of chloramphenicol for mod-

TABLE VIII
IMPORTANT TOXIC REACTIONS IN THE COURSE OF ANTIBIOTIC THERAPY

<i>Reaction</i>	<i>Penicillin</i>	<i>Streptomycin</i>	<i>Aureomycin</i>	<i>Chloromycetin</i>
Anaphylactic shock	Very rare	Very rare	0	0
Skin eruptions	Common	Common	?	?
Renal injury	0	0	0	0
Hematopoietic injury	0	Eosinophilia	0	?
Central nervous system injury	Very rare	0	0	0
Drug fever	Common	Common	?	?
Vertigo	0	Common	0	0
Deafness	0	Occurs	0	0
Nausea	0	0	Common	Occurs
Vomiting	0	0	Occurs	Rare
Loose stools	0	0	Common	Common
Mouth lesions (oral administration) .	Common	0	Occurs	Common

erately ill patients is based upon 60 milligrams, and for seriously ill patients, 60 to 120 milligrams of the antibiotic per kilogram of body weight. In either case, the daily maintenance dose is divided into four parts, one of which is given by mouth every six hours. Up to the present no preparation of chloramphenicol has been developed for parenteral use. *Neither aureomycin nor chloramphenicol should be given by the intrathecal route.*

Toxicity

The toxic reactions which may follow the administration of penicillin, streptomycin, or dihydrostreptomycin are well known. It would appear that reactions due to the sensitization of patients to these three antibiotics are increasing, and it should be borne in mind that dihydrostreptomycin and streptomycin can produce vestibular and auditory disturbances. As will be noted in Table VIII, the important reactions produced by aureomycin are nausea, vomiting, and loose stools (often amounting to a diarrhea). It is believed that the nausea and vomiting are produced in part by an exogenous factor in the present preparations of aureomycin which are available for administration by the oral route. The looseness of the bowels may result from a marked disturbance of the bacterial metabolism in the colon which is incident to the suppression of bacterial growth in that organ when aureomycin is being administered. Localized dermatitis has been noted when aureomycin ointment is being used and it would appear that on rare occasions a scaly or acneiform type of dermatitis occurs when aureomycin is being administered. Whether these rashes are coincidental or are the result of sensitization to aureomycin has not yet been proved. The same may be said of drug fever.

Chloramphenicol produces nausea and vomiting but to a lesser degree than aureomycin. Looseness of the bowels is frequently observed in patients receiving this antibiotic. A scaly skin eruption, the origin of which is not known, has been noted in the course of treatment with chloramphenicol. Granulocytopenia has been noted in the course of therapy with chloramphenicol. Both the granulocytic and erythrocytic series were hypoplastic.² Both aureomycin and chloramphenicol will produce an irritation of the

mouth if given in solution or as a powder by the oral route. Renal damage and damage to nervous tissue have not been reported in patients receiving either aureomycin or chloramphenicol.

Summary and Conclusions

How times have changed since Dr. Bedford's day! Then the physician in Allegheny County had little in his armamentarium against infectious diseases other than blood-letting and purging. Today, with relatively minor exceptions in the viral and bacteriologic fields, he has highly effective antibiotics with which to treat successfully the great majority of the infections which confront him in his practice. In Dr. Bedford's time the natural expectancy of life was about 30 years and the majority of Dr. Bedford's patients died of infections or from external violence. Now the span of life is almost at the proverbial three score and ten, and the chances of an individual in this country dying of an infection in 1950 are probably less than 9 out of 100, while his chances of dying of disease of the arteries, cancer, or some other chronic disorder are probably better than 83 out of 100.

What does this all add up to? It means that as a result of the rapid advances in the sanitary, public health, and medical sciences the length of life in these United States has been prolonged to an extent for which our social scientists, our economists, and our labor, industrial, and political leaders have hardly been prepared. It is my candid opinion that much of the social, economic, and political unrest which we witness today has, in part, its origin in our enormously successful endeavors in keeping people alive. We have outstripped the rest of our community. For this reason we must not be intolerant of the efforts of our fellow scientists and practitioners in the social and economic spheres to make haste towards providing those conditions which will make life not only permissible but also interesting for those we have saved from early death. We can only hope that their efforts will be based upon sound experiment and not on the empiricism of fright, emotion, or political expediency.

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The Psychiatric Unit in the General Hospital

Community Needs and Resources

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IN SOUTHEASTERN Pennsylvania lies Berks County, one of the largest counties in the State, ranking fourth in agricultural and industrial importance. It has 242,274 inhabitants. Age specific rates at birth indicate that 20,189 of its citizens can expect to be hospitalized for a nervous or mental disorder. The county has three well-run general hospitals with a total bed capacity of 765 beds. All these 20,000 odd nervous or mental patients needing specific inpatient care, rich and poor alike, must either be admitted to a largely charitable state institution at Wernersville or seek private care 50 to 100 miles away. This is in spite of the fact that the city of Reading alone has at least six full-time neuropsychiatrists and several part-time neuropsychiatrists engaged in private or clinic work, all of whom are well versed in inpatient psychiatric care.

Throughout the United States this situation is rapidly changing. In 1755 the Pennsylvania Hospital opened and "set the pattern for an enlightened program in the care of the mentally ill." "Although the New York Hospital had admitted mentally ill patients from the time of its opening in 1792, it was in 1808 that a separate division at a location removed from the general hospital was constructed and operated for the care of the mentally ill. In 1932 the establishment of the Payne Whitney Clinic as a division in the New York Hospital-Cornell Medical Center placed extensive psychiatric service again in close physical association with the main New York Hospital in New York City."

In 1902 the Albany Hospital established the first modern inpatient psychiatric unit in a general hospital in this country. This was followed in 1932 by the Henry Ford Hospital in Detroit.

Strong Memorial Hospital in Rochester, N. Y., opened a unit in 1926. Massachusetts General Hospital, under the direction of Dr. Stanley Cobb, established a psychiatric ward in 1934. Since 1902, 149 non-government general hospitals (Table I) have established psychiatric units and the number is steadily increasing. At least 37 Veterans Administration hospitals have complete psychiatric units in general and medico-surgical hospitals.

This is of great encouragement to medicine, particularly in the field where the government had such an enormous monopoly. It gives hope to those who feel that possibly government medicine would be irreversible; the story of psychiatry shows the first hundred years are the hardest. We in psychiatry are proud of the emergence of psychiatry from that of being a stepchild of medicine to being a full-fledged partner.

Philosophies of Medical Care

Today as the rapprochement of psychiatry and medicine slowly advances we are still hindered by well-demarcated philosophies. The welfare of the individual and the sanctity of the personality are caught up in a maelstrom of pernicious and selfish thinking. The patient has a right to assume that the physician will promote such social, political, and educational advantages as will decrease morbidity, and which will result in the quickest and most humane form of recovery.

Present in the world today are three distinct creeds as to the care of the mentally sick—totalitarian medicine, government medicine, and voluntary and private practice.

Totalitarian medicine is the most extreme form. In the late war in a castle in southwestern Germany, hundreds of psychiatric patients were put to death in the courtyard of the castle. The philosophy was: kill what you can't cure. This

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was done scientifically, and I presume even their euthanasia might have been explained by scientific factors. If, therefore, we say as we so often do that our patients are receiving scientific therapy, it might be well to add the nature and type of philosophy to which we adhere.

Another dogma of medical care is that of state medicine. The public and physician alike believe that the state will have to take responsibility for what we can't or won't do. For 100 years the government has had almost complete monopoly of one-half of all the hospital beds in the United States, devoted to the care of mentally ill patients. As far as the author is concerned the present state hospital system in this state or in any other state shows essentially the evils of what we call government medicine, or politically controlled medicine. The American Medical Association describes the salient features of politically controlled medicine as follows: "(1) It would invade individual privacy and destroy a sacred personal relationship between the doctor and patient. (2) Wherever it has been extended, political medicine has proved itself to be a cheap medicine, but cheap only in quality. (3) The cost goes up and up. (4) Your own doctor or Dr. X. (5) Staggering costs in taxes. (6) Freedom of choice versus compulsions." If we look at state medicine, therefore, through this microscope of politically controlled medicine, we will find the same factors operating which we object to in socialized medicine in this or any other country. Dr. George S. Stevenson, president of the American Psychiatric Association, wrote in 1947: "In the name of economy we have sold our heritage and allowed the state to prostitute psychiatry to the extent that patients do not have a free choice of physicians, and are deprived of community contact."

The state is not alone to blame for this. It is the people and the psychiatrists themselves who have brought this about. As stated by Dr. S. Weir Mitchell in an address given in 1894 before the American Medical Psychological Association, "You were the first of the specialists and you never came back into line. It is easy to see how this came about. You soon began to live apart, and you still do so. Your hospitals are not our hospitals; your ways are not our ways. You live out of range of critical shot; you are not preceded and followed in your ward work by clever rivals, or watched by able residents fresh with the learning of the schools."

TABLE I

PSYCHIATRIC UNITS IN GENERAL HOSPITALS FOR
UNITED STATES, PENNSYLVANIA, AND
BERKS COUNTY

Place	Year	Number
United States		
(excluding Federal hospitals)	1900	0
	1949	149
Pennsylvania	1949	4
Berks County	1949	0

There are other factors which are glaringly inappropriate in state medicine. Again quoting Dr. Stevenson, "Let us realize that the ills of the mental hospitals are not his (average citizen) evil intent, but the heritage of an outworn system which is wasting his money and opportunity. Under this system the mentally ill are "put away," so far away that they cease to be a part of his life. It is as though they no longer existed, as if putting them away had solved the problem. Under this system, which is so devoid of spirit, personnel of the best training and scientific inquisitiveness are not attracted and this adds further to the isolation. The precursors and early stages of mental illness are left without attention in the communities in which they developed and those patients who have recovered in the hospitals are returned home without the guidance that convalescent patients should have.

TABLE II

CUMULATIVE EXPENDITURE FOR LONG-TERM CARE OF
ONE PSYCHIATRIC PATIENT (ALL HOSPITALS)

1 year	\$ 731
5 years	3,655
10 years	7,310
20 years	14,620
30 years	21,930

"In this way the evil by-products of the neglect by society are constantly burdening it further: humanity and scientific treatment within the institutions are neglected and prevention of mental illness or the promotion of a higher level of mental health within the community is stunted."

The low rates that the state charges for psychiatric patients invite deceit, a paternalistic state, and lack of desire to get well. Time and again all of us have seen husbands and wives only too glad to have their spouses stay in the mental hospitals supported by the state. Too

many patients seek flight from reality who are encouraged by their relatives to do so without making an attempt to work out fine points of human interrelationship. In other words, we as taxpayers are inviting mental illness in our community by making it so cheap to secure hospitalization. It is a mistake to assume that only indigent persons become mentally ill. Fifty per cent of the patients admitted to state hospitals in 1947 are listed as "marginal" or "comfortable" in economic status, while only 50 per cent are "dependent."

Present indications are that the majority of state and some private mental institutions in this country do not meet the standards of the American Psychiatric Association for professional personnel. This means that such important therapies as insulin shock are largely neglected in many institutions. Yet we know from personal experience that insulin shock is the treatment of choice in many of the more severe schizophrenic reactions. Where treatment is delayed as much as three to six months, within the first year remission rates may decrease from 10 to 20 per cent. To those who think in terms of dollars instead of patients, a perusal of Table II is recommended. Although the average cost of maintaining a patient in a mental hospital is \$731 for one year, the table shows what it will be for five, twenty, or thirty years.

There are many factors to show why the cost of mental hospitals is steadily increasing. Table III might give one an idea of this problem. Maintenance and operation of mental hospitals in this state for the biennium of 1935 to 1937 cost \$8,500,000. For the biennium of 1947 to 1949 the same item will cost \$48,893,000—an increase of approximately 600 per cent. From personal experience the author knows that this is not enough money to give the patients the care

needed. So, before the state hospitals gobble up more of the budget, it would be wise to return partially to a system of voluntary, community-supported hospitals. Undeniably the state would still have a large duty to perform to indigent patients.

The third philosophy is that of modern private practice and of the voluntary hospital expressed in the story of the Good Samaritan and of the Hippocratic Oath: "I will follow that system of regimen which according to my ability and judgment I consider for the benefit of my patients." This forever precludes the good physician from following any impersonal régime. The story of the Good Samaritan further emphasizes that the physician at all times when he sees illness will do whatever is in his power to aid the patient. In all good conscience he cannot let it up to a third individual, the state, or any other organization. What justification do most hospitals have in calling themselves "general" when, in fact, they limit admissions to medical, surgical, and obstetrical patients? The general hospital is the main healing agency in the community. It is the health center for prevention and treatment of illness and the public has a right to expect that adequate facilities will be provided for all types of patients.

Survey of Pennsylvania

In a personal questionnaire (Table IV) to all hospitals of Pennsylvania, at least ten of them replied that they had definite psychiatric facilities in general hospitals. The Federal Security Agency lists four non-sectarian hospitals in Pennsylvania with such units. It would appear, therefore, that many hospitals maintain psychiatric units which they do not publicly segregate as such and possibly keep these units set aside for definite therapeutic purposes. Fifty other

TABLE III
PENNSYLVANIA MENTAL HOSPITALS
(Business conducted on biennial basis. Fiscal years June 1 to May 31.)

	1935-1937 <i>Biennium</i>	1943-1945 <i>Biennium</i>	1947-1949 <i>Biennium</i>
<i>Appropriations for</i>			
Maintenance and operation of mental hospitals	\$ 8,500,000	\$ 28,000,000	\$ 48,893,000
Construction of new buildings, alterations, purchase of land, etc.	303,978	7,101,000	60,951,000
Total	\$ 8,803,978	\$ 35,101,000	\$109,844,000
Total state budget	\$335,626,000	\$375,604,000	\$656,614,000
Percentage of whole budget appropriated for mental hospitals	2.62%	9.35%	16.73%

general hospitals routinely treat milder psychotic patients in general medical wards. Seven general hospitals give only inpatient electric shock therapy, while five give only outpatient electric shock treatment. Eleven general hospitals give both inpatient and outpatient electric shock therapy. Twenty-eight hospitals have an organized outpatient neuropsychiatric unit. It has been recommended that 1975 psychiatric beds be added to general hospitals throughout the State. This includes 30 additional beds for a hospital in Berks County.

Situation in Berks County

At present approximately one person out of every 287 citizens in the county is in a mental institution. This means that between 800 and 1000 citizens of the county will be in mental hospitals all the time. The majority of the 20,000 persons at birth, however, who may expect to be hospitalized will spend the greater part of their lives not in the mental hospital but back in the community. What happens to these sick people during their temporary residence in mental hospitals should be of great concern to the community.

Berks County has one of the highest suicide rates (Table V) in the United States. For the United States and Pennsylvania it is 11.5 per one hundred thousand, while in Berks County in 1947 it was 16.5 per one hundred thousand. What was the pre-morbid personality of these people? What extrinsic and intrinsic factors cause suicide? Is there an overwhelming cultural conflict? Would the presence of an inpatient psychiatric unit in local hospitals induce more persons to seek life than to seek suicide? The medical societies maintain special committees on appendicitis mortality, maternal mortality, anesthesia mortality, etc. Could similar committees on suicide mortality give us more adequate answers?

Suicide and acute depressions have become so severe in the Pennsylvania Dutch country that from recent newspaper accounts the Mennonites contemplate establishing their own mental hospitals. Rejection by the parents and an unyielding superego are observed to be major factors. For example, a 34-year-old female hung herself because she could never forget how her mother rejected her when 14 to marry another man; a 23-year-old man tried to hang himself because he was building a house which seemed too pre-

tentious to his culture and church. These problems must be worked out in the community, the church, and with the family by close day-to-day supervision and observation. To get treatment in a hospital is not enough unless the above dynamics are carefully and meticulously observed.

TABLE IV

PSYCHIATRIC FACILITIES IN GENERAL HOSPITALS IN PENNSYLVANIA (NON-GOVERNMENTAL)

<i>Type of Service</i>	<i>Number</i>
Hospitals with psychiatric units	10
Hospitals treating milder psychotics on general medical wards	50
Inpatient electric shock therapy (only)	7
Outpatient electric shock therapy (only)	5
Both inpatient and outpatient electric shock therapy	11
Organized outpatient neuropsychiatric unit ..	28
Psychiatric training for interns (73 hospitals have interns)	14

Advantages of a Psychiatric Unit

At the Reading Hospital an active consultation unit in psychiatry is available at all times. One out of every 13 admissions to the medical wards of a general hospital will present personality disorders. Hysterical patients are a problem in every hospital. Cobb, of Harvard, relates his experiences: "Incidence of appendectomy in these hysterical patients is extremely high. Of the 32 hysterical patients listed, 20 had appendectomies, whereas in 100 student nurses there were only 13 appendectomies. By keeping our eyes open for young hysterics who complain of abdominal pain and are rushed into the emergency ward, we have been able to recognize a number of them before operation and in some way relieved their symptoms by working out their troubles which are usually adolescent fears related to menstruation and menopause."

Keyes, Bookhammer, and Kaplan found that in 146 psychiatric consultations in the Jefferson Hospital in 1946, 50 per cent were for psychosomatic disorders, 31 per cent for psychoneuroses, 6 per cent for psychoses with organic conditions, 3.4 per cent for affective psychoses, and 8.2 per cent had no significant mental problem. Fetterman relates how many patients are suicidal, taking an overdose of poison or gas, are treated in an emergency room, and then immediately dumped back on the community. In such

TABLE V

(Rates per 100,000 Population)

NUMBER OF SUICIDES AND THE RATES IN UNITED STATES, PENNSYLVANIA, AND BERKS COUNTY (1947)

Place	Number	Rate
United States	16,152	11.5
Pennsylvania	1,180	11.5
Berks County	40	16.5

cases the family is unable to prevent the next and perhaps fatal suicide attempt. The general hospital has the opportunity here to go beyond giving emergency care. Ebaugh believes that if many chronic psychiatric cases had been offered early general psychiatric care their illness would not have been neglected and they would never have reached the stage of chronicity. Strecker estimates that 75 per cent of the clientele of the general practitioner in his first ten years have neuroses, organic disturbances complicated by neurotic conditions, etc. Rees and Billings estimate that in Colorado alone three to nine thousand psychiatric patients are annually being admitted to general hospitals. Many of these have physical diagnoses.

Many problems are frequently encountered in patients in general hospitals which require consultation or the institution of therapy, such as psychoses with encephalitis, confusional psychoses associated with cardiac decompensation, religious excitement occurring with fever, schizophrenic psychoses, postoperative states, delirium tremens, confusional states due to drugs, fever, toxic absorption, or situational factors, panic reaction, post-traumatic delirium, postpartum conditions, epileptic states aggravated postoperatively, confusion or delirium, insulin shock reaction, postoperative scare, cystoscopic addiction, contraceptive worries, impotency, premature ejaculation, homosexuality, atropine sensitivity, anxiety due to bandaging both eyes, senile confusion, hysterical blindness, hives, hysterical pain, headaches, and all of the classic psychoses and neuroses.

Of particular plight are the ill acute alcoholics. Many counties in Pennsylvania still lodge these people in jail without any medical attention or follow-up. Peter Bent Brigham Hospital and Harvard University, Yale University, the State of Virginia, and St. Luke's Hospital, Philadel-

phia, are doing outstanding work in the rehabilitation of these people through general hospital care.

Similarly, although a person may be old it doesn't mean that he is senile. The social and economic insecurities of old age may well precipitate a marked depression in many persons whose mental capacities are relatively unimpaired. Out of 365 mental patients, over 60 years of age, admitted to the New York Hospital, only 35 per cent had an organic brain condition, while 65 per cent were functional in type. These people should be admitted to a community general hospital for study and treatment. Once relegated to an insane asylum, the patient feels that he is done for and his family refuses further responsibility.

The general hospital itself is frequently treating psychiatric patients whom it refuses to recognize as such, often administering medieval punitive therapy which generally would not be allowed in well-run psychiatric hospitals. For instance, during the early part of 1949 the author treated or was consulted on the following patients: a 90-year-old male, semi-delirious, shackled in bed; a 30-year-old female, two days postpartum, with an acute psychotic episode, both arms shackled in bed; a middle-aged male, somewhat depressed, receiving electric shock therapy, in a private room with private nurses costing him at least \$50 a day. To the psychiatrist, shackles are considered a form of punishment, not a form of therapy, yet many hospitals refuse to set aside any locked ward space for patients. They are shackled to a bed or constantly guarded by private nurses so that they may not escape or commit suicide.

Table IV reveals that only 14 out of 73 general hospitals in Pennsylvania having interns offer any psychiatric training. This is in spite of the fact that such great clinics as the Lahey Clinic found that out of 1000 ambulatory patients

TABLE VI

EXPENDITURES FOR LUXURY ITEMS IN BERKS COUNTY (1948)

Dollar value of liquor sold	\$ 6,100,000
Sales value of beer sold	10,897,752
Dollar value of cigarettes sold	3,954,290
Total	\$20,952,042
Per capita (over 16 years of age) expenditure for above items	\$116

272 had purely nervous conditions, while 134 had both physical and mental disorders. Common sense therapy of emotional and psychiatric problems is not enough. One hundred years ago common sense treatment of abdominal pain was bleeding and purging. Midwifery was the common sense form of obstetrics. Much of the psychiatric training that our interns receive in Pennsylvania today consists of the same outmoded common sense measures which frequently aggravate a patient's condition, produce chronicity, and throw many into suicide or worse mental disorders. Some of the larger and better general hospitals offer well-supervised training in psychiatry and in psychosomatic disorders. The intern in Pennsylvania is required to have eight weeks in obstetrics and eight weeks in laboratory work. He is not required to have any training in psychosomatic or in psychiatric conditions. Yet most doctors will never deliver babies nor do laboratory work after internship. They will see emotionally upset people and without a dynamic conception of these problems will continue to muddle along.

Very few training schools for nurses in Pennsylvania have psychiatric facilities within their own hospital. Many nurses have to affiliate with nursing schools at a great distance, so that there is a great loss of nursing effort for the local hospital. For instance, at the Reading Hospital, the nursing class will eventually have 70 nurses who will affiliate for a three months' period at St. Elizabeth's Hospital in Washington, D. C. Although it is true that student nurses could not carry the work forward as far as graduate nurses, yet at this one hospital more than 17 nurse years of work will be lost to the community in one year's time.

Disadvantages of a Psychiatric Unit

The average hospital administrator thinks of many disadvantages. One thing frequently mentioned is stigma. As these administrators become more aware of the fact that such problems are being faced in an objective way and that the treatment of mental disorders is now on the same rational basis as that of the ordinary medical and surgical illness their attitude will be of less concern. It is this stigma that has been an important factor in so many cases being neglected, and it presents a real opportunity for the general hospital to serve an educational function.

It is complained that psychiatric patients are noisy. A well-managed psychiatric ward probably has less noise than the average obstetric, pediatric, and surgical ward. Heldt discloses that during three years and ten months there were two suicides in the psychiatric ward of the Henry Ford Hospital, while there were three suicides among patients in the other wards of the hospital. Suicide is not a major objection.

Resources

Public law 725 passed by the 79th Congress authorizes grants to the state for surveying hospitals and for planning construction and authorizes grants to assist in construction. Act 89A of 1949 of the Commonwealth of Pennsylvania states: "To the Department of Welfare . . . for the purchase from publicly or privately operated non-sectarian hospitals not exceeding five dollars and fifty cents (\$5.50) per day of psychiatric treatment and maintenance of mentally ill persons admitted to such hospitals who are entitled to free service for such periods per person as the Department of Welfare may approve and for assisting such hospitals to establish facilities for the care and treatment of the mentally ill such assistance to be limited to one thousand five hundred dollars (\$1,500) per bed." As far as is known, however, funds are not available for this purpose.

The average length of stay of these patients in a psychiatric unit in the general hospital is approximately 21 to 24 days. The majority of hospitals charge from \$12 to \$14 per day. Blue Cross covers much of this.

Surprisingly enough, people do have money to pay for these modalities. Even in Berks County money is available. A personal survey (Table VI) by the author of various expenditures for luxury items discloses that every man and woman in Berks County over the age of 16 years voluntarily spends \$116 per year for liquor, beer, or cigarettes. This does not include any other luxuries. Can a so-called enlightened and civilized people say, therefore, that voluntarily they cannot pay for psychiatric care?

Type of Unit

Cameron believes that every 400-bed general hospital should have an 18-bed psychiatric unit. Frequently, existing hospital wings may be renovated. At Bishop Clarkson Hospital in

Omaha a 30-bed unit was established at a cost of \$19,000 by renovating a general hospital unit. Barnes Hospital in St. Louis has an ideal unit completely air-conditioned and soundproof.

Bradley estimates that the rough cost of equipping a unit would be \$600 per room including screens. This, of course, does not include construction of the building. The United States Public Health Service has done much planning on the suggested type of psychiatric ward for a general hospital, in consultation with the American Psychiatric Association.

The following factors are essential to the successful operation of such a unit: (1) an enlightened public policy; (2) a board of directors having faith in such a unit; (3) competent supervision; (4) an adequately trained staff of psychiatrists, psychiatric nurses, psychiatric attendants, social workers, psychologists, clerks, etc.; (5) of course, not the least of these is a specially constructed or remodeled unit. For such a unit to be self-supporting, it should have at least 30 beds. It must not serve as a lockup or dumping ground of a general hospital. The service with a minimum of 50 beds can sustain itself from patient income alone and at the same time take a limited number of free, part-pay, full-pay ward or semiprivate patients.

Warson from the Barnes (McMillan) Hospital states: "There has been such a demand for beds that long waiting lists have developed . . . our turnover is rapid, about two patients a day, but we can't keep pace with demands for such service." Psychotherapy of a dynamic type must be paramount. Insulin shock, electric shock, occupational therapy, hydrotherapy (including continuous tubs and wet packs) are all indicated. Psychosurgery is also indicated in many instances. Although of necessity strict psychiatric principles must be observed, the family physician, community agencies, and the family itself can give valuable aid. Frequently, this is impossible in distant private or state hospitals.

An integral part of an inpatient unit is a well-established outpatient department. The Reading Hospital has had such a unit for many years under the direction of Dr. Frederic H. Leavitt, of Philadelphia, with Dr. John Bower and the author as associate neuropsychiatrists. Two clinical psychologists are also in constant attendance at the clinic. Electro-encephalography and outpatient electric shock therapy constitute an im-

portant function of outpatient work at the Reading Hospital. These two functions have proved to be an important source of revenue to the hospital similar to that of the x-ray or the laboratory departments.

Discussion

It is obvious to the reader that the author is in favor of psychiatric units in general hospitals. There is no parallel in American medicine to that where a patient comes to a specialist for therapy and where the specialist must do so much cajoling, bickering, and explaining to have the patient accepted for treatment in a hospital. (This is not true of Dr. Hill at Wernersville). How suicidal or how mentally ill must a patient be before he can be admitted to a hospital for therapy? This is identically similar to the question which might be asked of a fire company: how big must the fire be before the fire company will respond? Yet today in our system of expensive private hospitals and of overcrowded state hospitals the patient invariably must show that he has been very sick for some length of time or that he is extremely suicidal before he can be admitted for treatment. It is these very patients who eventually may become the burdensome patients of a state hospital system and who would benefit by early community therapy.

The problem today, therefore, resolves itself not into whether or not we are being scientific or whether therapy is necessary. The problem is: do psychiatric patients have the same rights as other patients? Do they have the right of free selection of physician? Do they have the right to be treated in voluntary hospitals or must they be treated in exclusive private hospitals or charitable state hospitals? Are we hedonistic, selfish, and self-centered, or can we return to the principle of the Good Samaritan and give treatment whenever and wherever needed?

Conclusions

The following conclusions may be drawn from this study:

1. The type and degree of therapy available to mentally ill patients depend primarily on deep moral principles. Pure scientific interest is not enough.

2. An increasing number of communities in the United States offer psychiatric therapy to the patients in community general hospitals.

3. Communities like Berks County, Pennsylvania, have enough patients and sufficient resources to warrant an inpatient psychiatric unit in a general hospital. Ancillary benefits such as

intern and nurse training and community orientation are not without merit.

EDITOR'S NOTE: A copy of bibliography will be supplied upon request.

VARYING VALUES OF CORTISONE FOR ARTHRITIS CONFIRMED

The remarkable action of cortisone, formerly called Compound E, in relieving rheumatoid arthritis has been confirmed by studies made by two Los Angeles doctors.

Drs. Edward W. Boland, assistant professor of clinical medicine at the University of Southern California School of Medicine, and Nathan E. Headley reported that they have used the hormone substance to treat eight patients.

Cortisone is still extremely scarce, they point out, and available supplies are being used at research centers to study its effect on disease and the human body.

Supply of the hormone preparation is the greatest problem in making it generally available. Present methods of production require a basic ingredient known as desoxycholic acid, which is obtained from the bile of oxen. Only one pound of this ingredient can be obtained from 130 pounds of bile. Science must discover some natural source more plentiful than this or achieve a method to make cortisone from raw chemicals.

In three of the severe cases treated, improvement began within a few hours after the first injection of the drug, the doctors report in the October 1 issue of the *Journal of the American Medical Association*.

One patient who had been barely able to get out of bed without assistance at 11 o'clock in the morning when the first injection was given was able to get in and out of bed with ease and walk freely about the room in the evening of the same day.

A woman who had been unable to bring her hands to her mouth or to handle eating implements was able to feed herself 24 hours after the first injection.

The first symptoms to subside were muscular stiffness and pain. In 24 to 48 hours these patients no longer needed pain-relieving drugs. Next in order of improvement were increased motion and decreased tenderness of the joints.

The rapid return of muscle strength and joint function despite advanced wasting away of the muscles and previously restricted joint motion was remarkable, the doctors say. Four of the five patients with severe disease had pronounced wasting away of muscles; yet after a week of cortisone treatment they walked, got on and off chairs, and climbed stairs with ease.

Improvement in all except one of the severe cases was temporary. Symptoms began to reappear in two to six days after cortisone was discontinued, and in from

three to six weeks the disease was as bad as it had been before treatment with the hormone substance. One patient has retained much of her improvement two months after discontinuance of cortisone.

Treatment of three additional patients with less severe rheumatoid arthritis brought adequate but also temporary improvement. Results suggest that smaller doses of cortisone than those used in early tests at the Mayo Clinic may be sufficient to control mild and moderate cases of the disease, the doctors say.

WHAT MAKES A PHYSICIAN GREAT AND WORTHY OF GREATNESS

The passion for truth and accurate observation; the passion for good listening and hard work; the passion for curiosity as to why an individual behaves as he does; a passion to help make a better man or a better personality so that in turn he can contribute a portion of himself for a better human race; the passion to find the basic organic cause or the basic psychologic and repressive factors and to instill hope and motivation; the passion of creativeness to rehabilitate and develop the unique individual self—such are ingredients of greatness. Today, we, as physicians in a complex, rapidly changing world, technologically can, by our station in life as a friend and teacher, create an attitude or philosophy in which the human spirit has an opportunity to rise, to grow, to improve, to aspire.

The physician's job is more than cutting with a scalpel, writing a prescription, giving shots with a syringe, or laboratory testing to satisfy our insecurities so that we may pigeonhole a patient with a label. We must all gain more psychiatric insight as to the total human personality and the factors that dwarf and impoverish it.

It is more tantamount and paramount, as Osler said, that "The practice of medicine is an art, not a trade, a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with the potion and powders, but with the exercise of the influence of the strong upon the weak, the righteous upon the wicked, the wise upon the foolish."

When we are as truly worthy of our station as the physician in Luke's painting, we shall not have to be afraid of socialized medicine ever coming. H. H. Kato, *Rocky Mountain Medical Journal*.

Management of the Patient with Pain Due to Advanced Carcinoma of the Prostate

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THE WORDS "advanced carcinoma of the prostate" are used to connote a state of affairs in which the patient is beyond hope as far as curing his disease is concerned but who has had his obstructive symptoms relieved and later had pain develop from local extension or distant metastasis. The curing of the disease and the relief of the urinary symptoms belong exclusively to the urologic specialty. The relief of pain is a problem which involves the entire field of medicine, but perhaps more particularly the neurosurgical field. This may well be so because the perception, conduction, and interpretation of the painful stimuli are fundamental functions of the nervous system.

Besides pain, there are other involvements of the nervous system which fall in the field of neurosurgery and are produced by the spread of prostatic malignancy. The involvement is no different from that produced by other neoplasms of the central nervous system. Involvement of the brain by metastatic prostatic malignancy is not common, but that of the spinal epidural space is relatively so. Therefore, there are two major directions for neurosurgical efforts in the treatment of the patient with advanced carcinoma of the prostate. One is to relieve pain; the other is to relieve the effects of actual neoplastic involvement.

The relief of pain has occupied the thoughts of mankind since earliest time when various narcotic and soporific drugs were developed from herbs, grains, etc. Many of these are still in use. The most common, of course, is our old friend *spiritus frumenti*, who at times gets so out of hand. There are also the derivatives of opium and the recently rediscovered "pitcher plant" extract. The most recent medications are the syn-

thetic compounds given orally or hypodermically. These medications all produce their effect by dulling the interpretive portion of the central nervous system to the point where painful stimuli no longer produce distress. Strangely enough, the most recently developed surgical approach to the problem brings us back to this most fundamental portion of the mechanism.

Later in the progress of medicine, when anatomy and physiology revealed the nerve mechanisms concerned with perception and conduction of pain, a more direct attack was begun upon the pain complaint. Nerves were severed and fiber tracts destroyed. Perhaps the most fundamental attack upon the problem is the eradication of the cause of the pain, in this way eliminating the peripheral stimulus, and this, of course, is where the urologist comes in with the excision of the tumor itself, the castration, and here also belongs the effect of x-ray therapy.

Now, although in the preceding paragraphs we came from the top and worked down, the attack on the problem which we ordinarily follow is almost in the reverse order except for the use of the narcotic, analgesic, and soporific drugs. We assume, as I mentioned, that the obstructive symptoms are relieved by whichever means are preferred. The next step in our clinic is usually castration and this is now ordinarily done when the diagnosis is made. In larger series of patients than ours this has evidently been quite satisfactory in relieving the pain of extension or metastasis. But, as will be shown, our own group of patients from the percentage standpoint had about the same frequency of complications. In a certain percentage of patients (in our series 15.5 per cent of those castrated) complicating pain developed due to extension or metastasis which required further therapy for relief. Our next step is to give a course of x-ray therapy. This will frequently arrest the spread of car-

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cinoma, but may in a few instances be of the analgesic type. In the majority of instances this is effective the first time it is given, and in our group of patients, castrated or not, of the nine who had x-ray therapy, six were sufficiently relieved to finish their existence in comfort. At times we feel that the failure of x-ray therapy to relieve pain may be explained by the fact that the rays are directed to the improper site. This is especially true of radiating pain or referred pain from carcinomatous involvement of the spine.

We now come to the next phase of the attack upon the patient's complaint of pain, and this is where my own field of endeavor is utilized. Peripheral nerve section, crushing, or injection is rarely useful since the pain of a metastatic lesion is rarely localized enough to be helped. A simple and fairly successful method of partially anesthetizing localized painful areas is that originally described by Dogliotti of using subarachnoid injections of absolute alcohol. This procedure, if carefully performed, is quite safe and is effective in about 50 per cent of cases. It is essential that the patient be properly positioned on the table and even more essential that the alcohol be injected in the portion of the spinal canal in which the roots affected arise from the spinal cord and not where they emerge from the canal. This, of course, places the site of injection several segments above the counted spinous process. It is also essential that no more than 1 cc. be used and that it be injected slowly (3 minutes by the clock or watch). The injections cannot be repeated more frequently than two weeks if the first is not effective. Patients with bilateral pain are poor subjects for this procedure. Complications are rare, but do occur as I will mention. If injections for bilateral pain are done, bladder paralysis is frequent even though temporary.

The next step in the management of these patients is the surgical division of the tracts, the lateral spino-thalamic pathway in the spinal cord, as originally designed by Spiller and carried out by Frazier, late members of this society. Unilateral or bilateral sections can be done as indicated, but a patient with a metastatic carcinoma should ordinarily have bilateral sections done since we and others have found that as soon as the pain is stopped on one side the patient almost immediately becomes aware of pain on the normal side, which undoubtedly had previously been

overshadowed. Our best results have been obtained when the operation was done on a patient who was awake, so that he could be tested for pain as the pathways were divided. The ordinary operation is done at about the fourth thoracic segment for abdominal, pelvic, or leg pain. If the pain is from a higher metastasis, and we have had only one such case, it may be necessary to perform the section higher up or even in the brain stem, as recently described. The operation is not too shocking and even quite debilitated patients stand it surprisingly well. There should be no complications from the unilateral operation, and from a bilateral procedure there is usually only temporary urinary retention. The patient has sensation in the legs and body after the operation, but it is obviously not a normal sensation; this is at times disturbing and he may need a good deal of encouragement to enable him to return to an active status.

The next phase of the direct surgical attack on pain comes back to our first premise in this presentation—that of destroying the patient's appreciation of the painful stimulus. This can be done by excising the sensory cortex of the cerebrum. Again usually this would of necessity be a bilateral procedure requiring two extensive craniotomies. A more recent innovation is the prefrontal lobotomy originally described by Moniz in Spain and introduced in this country by Freeman and Watts in Washington for the treatment of mental disease and recently for the treatment of intractable pain of many origins. Still more recently unilateral prefrontal lobotomies are being done with evidently fair success as noted by Scarff in New York and Koskoff here in Pittsburgh. These last two procedures for pain have not been carried out as yet in our clinic.

In reviewing our own series of patients we selected those in whom a diagnosis of carcinoma of the prostate was made in the years 1941 and 1942, when 23 were found, and the years 1946-47-48, when 64 were found. The reason for the selection is the fact that 1941 was the year of advent of the neurosurgical service at the clinic and then part of 1942 and the intervening years were spent in the Navy. In 90 per cent of these patients the diagnoses were made by means of transurethral resections or biopsy of metastasis.

In the first group the fact that no chordotomies or alcohol injections were done may be noteworthy. There were only 8 castrations (35 per cent), and 2 patients were thought to require

x-ray therapy for relief of pain. This is 8.9 per cent of the group and strangely enough corresponds with the number in the second group in which 6 patients of 64 or 9.3 per cent received x-ray therapy. In the former group, of the two receiving x-ray therapy, one was castrated. In the latter group all those receiving x-ray therapy were castrated. In the second group, 50 or 78 per cent of 64 patients were castrated, and, of these, six as mentioned required x-ray therapy to control the pain of metastasis. Of these, two later required alcohol injection and three required chordotomy. One had quite well localized pain which was relieved by an alcohol injection and no other treatment.

Of the patients receiving alcohol injections, one was improved enough so that nothing further was necessary in the remaining nine months of his life. In the second one alcohol injection was successful for nine months, but then there was recurrence and spread of pain and eventually a chordotomy was done, which gave him relief for a month. In the third it was done to help raise the sensory level in a chordotomy which did not reach quite high enough and was successful for the six months that the patient lived.

Three chordotomies were done—two bilateral and one unilateral. All may be classed as successful, but one was done so late that the patient obtained little comfort from it. This patient is the one who had the alcohol injection from which marked weakness of the leg developed for three months.

One patient was admitted to the hospital with evidence of cord involvement due to pressure and with no bladder complaints. Operation revealed a metastatic carcinoma of the prostate and the latter was not disturbed. He was comfortable for nine months and then died at home from an acute abdominal upset. No autopsy was done.

Perhaps a brief mention of two cases will bring home more forcibly the points we wish to establish.

CASE 1.—A 60-year-old man was admitted to the hospital with urgency, frequency, and swelling of the left leg. A diagnosis of prostatic carcinoma was made by palpation and a castration performed. He improved remarkably and had no further complaints until three and one-half years later when the leg again became edematous and this time painful, too. There was marked enlargement of the prostate and it was stony hard, but there were still no obstruction complaints. The pain was well localized and x-ray showed no osseous metastasis. Injection of 1 cc. of absolute alcohol stopped the pain until the patient died ten months later.

CASE 2.—In September, 1945, a 52-year-old obese white man was admitted to the hospital with the complaint of difficult urination for a year. Examination by palpation revealed a carcinomatous prostate, and castration was carried out. He had no actual obstructive symptoms at the time. He returned in four months complaining of pain in the perineum and x-ray showed bony metastasis in the pelvis. A course of x-ray therapy was given which gave relief. He returned in two months with obstructive symptoms and a transurethral resection relieved these and verified the diagnosis.

Then in August, 1946, eleven months after his first appearance, a bilateral chordotomy was done because pain had recurred and a second course of x-ray therapy had no effect on it. A satisfactory level was obtained on the left side, but on the right it was obtained only to about the first lumbar segment, so an alcohol injection a month later was done, with relief of residual right lower quadrant pain.

He was then comfortable as far as pain was concerned, but complained of a strange, burning sensation in his legs when he stood or walked and was therefore in constant need of encouragement to be ambulatory. He died in January, 1947, of generalized metastasis.

In conclusion we would like to present the following suggestions for the management of these men:

1. Establishment of the diagnosis, preferably by transurethral resection and the simultaneous relief of the obstructive symptoms. Some urologists, of course, at this stage advocate perineal removal of the gland and mass, but that discussion is outside the realm of this paper.
2. Orchidectomy when the diagnosis is established, but this is also a matter of individual preference.
3. Administration of milder analgesics and occasional narcotics for the pain of metastasis for the first weeks until certain that the metastasis is the cause of difficulty.
4. A course of x-ray therapy as outlined by the roentgenologist. This may be repeated subsequently.
5. Alcohol injection for localized pain and chordotomy, unilateral or bilateral, as soon as it is established that other methods are ineffective and before the patient is moribund or a narcotic addict. At this stage future experience may lead to a wider use of the prefrontal lobotomy operation in preference to the chordotomy.
6. Spinal cord decompression by laminectomy for those patients with paralysis of legs and bladder and bowel from epidural metastasis. This again should be done early before the man is totally paraplegic.

Immediate Treatment of Soft Tissue Injuries

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IN THE field of plastic and reconstructive surgery our interest centers repeatedly upon the healing of soft tissue wounds. Various observations and accepted methods of treatment which have proved valuable to us deserve further emphasis.

Any laceration of the skin and deeper soft tissues, during the first six to eight hours, may be considered only as a contaminated wound. Therefore, by full gentle cleansing with mild soap and water to the adjacent skin areas, and generous quantities of saline irrigation to the wound itself, we should be able to convert a contaminated, dirty wound into a clean sterile field which is ready for immediate closure. If the wound is older than eight to ten hours, it would be preferable to bury only small amounts of catgut to approximate the deeper muscle and subcutaneous layers, close the skin edges accurately but not tightly, and rely upon the sulfonamides and antibiotics to control what little infection may already have become established.

When strong antiseptics are poured into an open wound, many living cells are destroyed along with some of the surface-contaminating bacteria, and in some cases infection develops rapidly in this splendid culture media of devitalized tissue. We are convinced that the most effective way to render a contaminated wound sterile is by gentle mechanical cleansing and irrigation of the tissues with normal saline solution.

In a dry field it is now important to investigate the depths of the wound for any remaining foreign body and to evaluate the extent of damage to the deeper muscles, tendons, and nerves. In the first few hours of a wound thus rendered clean, it is preferable to anastomose all sectioned tendons and nerves. In a similar manner lacerations of muscle and the overlying fascia should be closed accurately with sutures. Torn and

bruised edges of skin or deeper tissues should be trimmed away, providing a clean-cut edge for better approximation and healing.

In lacerations of the face where a more meticulous closure is desirable, there are several features of interest. It is of great importance to secure accurate approximation of the subcutaneous tissues with 5-0 catgut or silk, and thus prevent a depression of the scar which might become adherent to the underlying muscle layer. If ragged or oblique skin edges are trimmed accurately, a finer closure can be achieved with 6-0 silk or any other light suture material. Fine interrupted sutures, tied only tightly enough to approximate the skin edges, and never tightly enough to blanch the skin, will leave no visible suture marks if removed by the second or third day. It has been our observation that equally fine scars can be obtained by employing any one of six or eight acceptable fine suture materials. It is never the suture material but the manner in which it is employed which permits accurate healing of the skin edges for a fine line scar.

We place great emphasis upon moderate pressure dressings applied accurately to each sutured laceration or surgical closure. Pressure minimizes the extravasation of blood and serum into the tissues and reduces the edema during the healing period. Pressure likewise aids in immobilizing the sutured skin edges and underlying tissues, which is a factor of considerable importance in clean primary healing. Since immobilization in fractures is paramount, is it not reasonable to assume that soft tissue immobilization is likewise beneficial to the healing process?

In the occasional case, when a large flap of avulsed skin and subcutaneous fat has only a narrow pedicle attachment, it is preferable to remove it completely and replace the skin as a free graft. If every trace of fat and even some of the deeper layer of derma is removed meticulously with the curved scissors, the chances for a successful take are infinitely better than resuturing the avulsed

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flap of skin, which frequently becomes engorged with venous blood, leading to necrosis.

In areas where there has been actual avulsion and loss of skin, it is a simple matter to cover this raw area with a free split skin graft. Wounds involving loss of the soft tissue pads of the fingers, for example, can be covered by small free split grafts for quick healing, or reconstructed immediately by the application of a small pedicle of skin and fat from the chest wall. Either method is preferable to a grease gauze dressing, which does permit slow epithelial coverage but leaves a tender painful scar on the sensitive end of the finger.

Finally, the sulfonamides and antibiotics can be employed with great advantage in reducing the incidence of infection. Their use, however, should never be a substitute for the fundamental principles of clean, gentle surgical care of soft tissue injuries.

Conclusions

The important features of the immediate treatment of soft tissue injuries are:

1. Adequate, gentle cleansing of the tissues to convert a contaminated wound into a clean field for closure.
2. Investigation and repair of the deeper damaged structures in the early wound.
3. Removal of devitalized tissue and trimming of torn edges for better healing.
4. Accurate closure of the wound edges in layers using fine suture material, particularly for facial lacerations.
5. Moderate pressure dressings to minimize the extravasation of blood and serum and contribute to the immobilization of the skin edges for better healing.
6. Use of the sulfonamides and antibiotics as an adjunct but never to replace gentle, clean surgical care of the tissues.

IMPLEMENT DEMOCRACY

The doctor and the teacher have much in common. Both are concerned with the growth and development of children. Both must have a social sensitivity to the total needs of people. Together they must work in their respective communities to provide the environment and the knowledge that will enable their clients to remain well. Since people can live fully and efficiently only as they are comparatively well, the physician's part in our lives is truly significant.

Both the profession of medicine and that of teaching have a rich heritage and tradition. These are too little known by many of our people. They are a part of our common American heritage which should be taught in our secondary schools and colleges. It is an inescapable responsibility of schools to teach these as a part of the foundation of our American way of life.

What is this way of life? Space permits only hints. It means the right to choose our profession, to worship God as we will, to live in the community of our choice, to send our children to its schools, to vote for its officials, to join its lodges, to paint our house the color we wish, to have a flower garden, and to modify our government. These things give us free enterprise.

Free enterprise is not something that the business man only wants. It should be something that the worker, the doctor, the teacher, and engineer want and will want, in most instances, if they understand what is at stake. But we cannot leave the telling to those who have lost faith in the American way. Our community leaders must make democracy work in their locality. They must tell of its achievements and possibilities—and then tell them ten times again.

In these fast moving days, our thoughts tend to become confused. Some say our people want security only. None want security carried to such a point that freedom of choice and a chance at advancement would be eliminated; nor do we expect something for nothing. We know that all advances have been and will have to be won. Our people want the security that will assure their family good medical care and the opportunity of securing the schooling their desires and abilities permit. This is also a part of the American way of life.

Can these things be better secured through the proposed welfare state? Or, through the implementation of democracy in our various communities? How much regulation can we take and still remain under the democratic processes? How can we, who do not believe in the big welfare state, most properly prevent its coming?

These again are questions which our people must critically study and those who know the implications must not only teach the choices before us but also see to it that the desires of our people for health and education are met. Changes are inevitable but they should be for the better. We do not want security that will lose us our rights as individuals. Only the democratic processes develop the dignity of the individual. Fascism and communism tend to destroy it.

Let's resolve to progress according to the American way and each in our own sphere help make democracy work. If we could have this resolve spread widely and undertaken energetically, we would have little to fear from "isms."

Let our slogan then be: Implement the principles of democracy so our people will want no other form of government.—*The Wisconsin Medical Journal*.

Hypothyroidism in Infancy and Childhood

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CRETINISM is one of the best defined and most easily recognized of the endocrine disorders.

Failure of development of a functioning thyroid gland in the fetus results in athyrotic cretinism. The parents of this type of cretin have normal functioning thyroid glands, and the fetus during intra-uterine life receives thyroxin from the mother.

An endemic cretin has parents, one or both of which have a defectively functioning thyroid gland. This type, therefore, is a true example of hereditary thyroid deficiency.

The athyrotic type is common in the United States, while the endemic variety is seldom encountered.

The signs and symptoms of cretinism may be conveniently grouped into four categories, as suggested by Gesell¹:

Metabolic—including low temperature, slow heart rate, no perspiration, poor appetite, constipation.

Infiltrative—including thick tongue, myxedematous infiltrations, thick skin, fatty pads.

Skeletal—including short stature and excessively short legs, slow dentition, delayed fontanel closure, and delayed development of epiphyses.

Developmental—including amentia, slow reaction time, and sluggish emotional response.

The syndrome of subnormal temperature, slow heart rate, a persistently wide fontanel, dwarfing with disproportionately short legs, and subnormal and sluggish behavior patterns should arouse a suspicion of hypothyroidism. It further justifies the administration of thyroid substance as a diagnostic test.

Myxedema is a state of thyroid hypofunction, coming on some time well after the neonatal period. The factor or factors responsible for de-

generation or suppression of function of the thyroid gland are not definitely known.

In general, the characteristics of myxedema tend to approach those of the untreated cretin, but are prevented from doing so because of its later onset in life.

The clinical picture varies considerably depending on the age of the patient at time of onset and whether or not any functioning gland remains giving off traces of thyroxin.

The myxedematous patient is usually seen earlier by the physician than is the cretin, because parents recognize characteristic changes from the normal more quickly in the older child. In patients of school age, moreover, the school teacher is very likely to call attention to the marked change in the caliber of the child's class-work.

Ordinarily, one finds a dry, cool skin of peculiar yellowish pallor. The hair is dry and thin and the face is round and expressionless with a broad flat nose.

Often the child has a puffy appearance and is slow in thought and action. The stature is short and the presenting complaint is mental apathy, along with failure to grow. The teeth are often carious and show faulty development.

Diagnostic aids which have been used to confirm the clinical impression of hypothyroidism in children range from growth charts to various biochemical determinations on bodily fluids.

The Wetzel grid is an exceptionally valuable graphic aid in determining early stage nutritive failure and developmental retardation. When used routinely it serves to detect early significant signs of deviations from normal.

In the diagnosis and treatment of hypothyroidism in the child, the study of the osseous development or determination of the "bone age" is one of the most dependable and informative procedures. Serial x-rays taken of these centers over a period of time give an index of physical response to therapy. Likewise, accurate chart-

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ing of developmental progress through performance tests is of considerable diagnostic and prognostic significance. The physical characteristics of hypothyroidism usually change very readily even with very small doses of thyroid. However, the patient may lag further and further below the level of normal mentality unless accurate developmental records are kept so that adequate dosage is given.

It is quite difficult to accurately measure the basal metabolism in children. This is partially true because of confusion of standards for children and partly because of lack of cooperation on the child's part during the test. Where values are dependable, they are found to be characteristically reduced in cases of hypothyroid function.

Reliable chemical methods are available to determine blood cholesterol and urinary creatine values. The levels of urinary creatine and blood cholesterol do not differ greatly enough in the untreated hypothyroid patient and the normal child to be of value.

However, Wilkins² has devised a means whereby these values can be used as measuring sticks to determine the effect of thyroid therapy on the patient. The levels in the hypothyroid patient respond sensitively to small doses of thyroid, whereas in the normal child the response is very much less. In addition to this, he has given the thyroid-stimulating fraction of the pituitary gland and studied the effect upon the levels of cholesterol and urinary creatine and the basal metabolic rate. He regards a positive response as being indicative of the thyroid that is present and capable of reacting to stimulation. It is an important observation that when a hypothyroid patient who has been receiving thyroid has the medication discontinued, the blood cholesterol rises very rapidly, while this change does not take place in the non-hypothyroid patient previously receiving thyroid medication.

Recently Johnston and Howard³ presented an excellent article dealing with hypothyroidism as a contributing cause to the celiac syndrome. Here again they point out the effect of thyroid on protein metabolism as previously reported from their clinic. Johnston and Maroney⁴ had also shown before that normal retentions of calcium could be expected only with a normal level of thyroid activity.

It is significant that the addition of thyroid along with the regular items of management in 18 cases of the celiac syndrome under their care

notably shortened the duration of symptoms, in contrast to 17 cases treated with diet alone.

The determination of serum-precipitable iodine as a routine diagnostic aid does not seem to be practical at the present time.

Talbot and his associates found the basic phosphatase to be consistently below four units in the cretin. However, in a controlled series Johnston and Howard³ found phosphatase levels below four when there was no other evidence of hypothyroidism.

Myxedema may be present as a result of deficiency of the thyrotropic hormone due to primary anterior pituitary disease. In 1944 Dunn⁵ reported 5 such cases and referred to them as infantile pituitary myxedema or cretinous pituitarism.

These cases may show an extremely enlarged sella turcica on x-ray examination and this procedure is a valuable aid in differential diagnosis. Where this condition exists, it is essential to administer anterior pituitary extract combined with thyroid in order to properly establish growth and gonadal development.

The chances of satisfactory treatment of hypothyroid disease in infancy and childhood are improved by early diagnosis, but this does not govern the entire outcome. Of this Gesell⁶ states: "The ultimate influence of thyroid substance on the hypothyroid patient is dependent much more on the residual developmental capacity and latent potency of his neuro-endocrine system than on his age or state of maturity at the time of diagnosis."

In treating children the desiccated gland is the product of choice. Small doses should be used at first and increased rapidly to tolerance. In order to accelerate the developmental rate sufficiently to allow the hypothyroid child to make up for his lost years, and to approach his normal age level, it is probably necessary to produce a slight degree of hyperthyroidism.

The appearance of irritability, tachycardia, continuous loss of weight, diarrhea, and sweating is evidence of overdosage and is an indication for reduction in the amount of thyroid given.

Dependable well-assayed products only should be used in the treatment. Not infrequently, hypothyroid patients have been given thyroid preparations for months and years before it has been discovered that the product being used is incapable of exerting any beneficial effect.

Thyroid medication should not be used indis-

criminally nor uncritically. Wherever used there should be at least a strong clinical suspicion that some degree of hypofunction of the thyroid exists. It should not for instance be used in juvenile obesity of exogenous origin, nor in uncomplicated cases of mongolism. Thyroid medication is distinctly of no value in the menstrual dysfunctions of adolescence unless a hypothyroid condition is definitely present. If uncritically administered, the thyroid substance may do actual harm to the patient.

In treating the hypothyroid infant or child,

nothing should be overlooked in supplying an adequate supportive vitamin, mineral, and dietary régime.

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WIRE AND RADIO TRANSMISSIONS OF X-RAY PHOTOGRAPHS AID TO ISOLATED HOSPITALS

A rapid and accurate method for reproducing x-ray photographs at a distance by wire or radio transmission is reported in the current issue of the *American Journal of Roentgenology and Radium Therapy*.

This development is regarded as a significant one, particularly for hospitals in rural communities, in military outposts, and in isolated mining and farming centers where the full-time attendance of a competent radiologist is not practical. The new procedure provides the services of a radiologist in a nearby large community.

Dr. J. Gershon-Cohen and A. G. Cooley, of Philadelphia, in a joint article tell of the daily successful use of roentgenographic facsimile between the Chester County Hospital, West Chester, Pa., and Dr. Gershon-Cohen's private office in Philadelphia, 28 miles distant.

Whenever Dr. G. W. Brown, training at the hospital, requires advice, he transmits the facsimiles and within a few minutes engages in consultation with his senior, using the same telephone circuit over which the pictures are sent.

"By the use of roentgenographic facsimile, the full advantage of an experienced roentgenologist can be obtained at all times, thus affording rapid roentgenologic consultation whenever needed, including emergencies," the authors report. "This also is a valuable teaching aid."

The apparatus comprises a transmitter and a receiver. The roentgenogram to be copied is wrapped around a glass cylinder and held in place by an envelope of clear plastic. The cylinder rotates at 180 revolutions per minute.

An optical scanning system projects a beam of light from an exciter lamp inside the cylinder through the wall of this glass cylinder and through the film onto a photo-electric cell. A special photocell circuit amplifier and synchronizing system is used, adopted from news-

photo facsimile equipment now used by newspapers and the weather bureau.

The optical scanning system traverses the length of the drum so that 50 lines per inch are scanned. This enables transmission of a 14 x 17 inch film in slightly less than four minutes and smaller films in proportionately less time. The signals may be sent over telephone lines or radio circuits in the same way that wire photos or radio photos are transmitted.

On the receiving end, negatives one-half the size of the original films are used. This receiving film may be processed in ordinary solutions in about half the time it takes to process regular roentgenograms. A hot blast of air may be used for quick drying.

"The facsimile retains all the detail of the original roentgenograms," the authors report. "Because of the half-sized reduction many details in it are sharper and more easily noticed than in the original film."

The article says that during World War II equipment having similar characteristics was used in regular service between Washington, D. C., and Anchorage, Alaska. It adds that excellent results also were obtained by the Office of War Information, which operated radio circuits over great distances, one of them between Chungking, China, and Los Angeles.

"It now seems probable that there will soon be available roentgenographic facsimile equipment which should prove to be a great aid in the solution of the problem of roentgenologic service for rural communities and various types of civilian and military medical outposts," the authors conclude.

... The Supreme Court long ago ruled that there was nothing inconsistent with the due process of law guarantee in the Constitution if the government saw fit 'to regulate that which it subsidizes.' From the beginning of President Roosevelt's New Deal this kind of development has been noticeable. Government aid means government control."—*The Columbus Dispatch*.

The Treatment of Fractures of the Shaft of the Radius and Ulna

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THE TREATMENT of fractures of the bones of the forearm presents a real challenge to the responsible surgeon because of the various types, locations, and sequelae. The difficulties encountered in fractures of the forearm will be illustrated and the methods of treatment described. The hazards of some forms of treatment will be discussed along with the care of non-unions and other complications.

Dr. John A. Key has stated that open reduction should be performed in fractures of the forearm when one attempt at closed reduction fails. This statement describes in general the policy carried out at the Geisinger Memorial Hospital and Clinic in regard to these fractures.

Fractures of the forearm, because of their relationship to soft tissues and the necessary variance in treatment at different levels, can be divided roughly into upper, middle, and lower third locations.

CLASSIFICATION OF FRACTURES OF THE FOREARM

Upper One-Third

1. Ulna

(a) Olecranon

Simple—internal fixation by screw or Steinmann pin.

Comminuted—excision of fragments and plastic repair of triceps tendon.

(b) Shaft

Closed reduction if possible.

Open reduction with intramedullary fixation by Steinmann pin. Plating?

(c) Monteggia fracture

Replacement of the head of radius and suturing of torn capsule. Ulnar shaft as in (b).

2. Radius

(a) Head

Children—replacement of part.

Adults—excision of head except lineal fractures without displacement.

(b) Shaft

Open reduction usually indicated. Plating?
Intramedullary Kirschner wire.

Middle One-Third

1. One bone

Closed reduction.

Open reduction—intramedullary fixation, or plating, if necessary to stabilize fragments.

2. Both radius and ulna

Closed reduction. Fluoroscope?

Open reduction—intramedullary fixation; one or both bones.

Lower One-Third

1. One bone—closed reduction difficult; open reduction may be necessary.

2. Both bones—usually reduced by closed methods.

Closed reduction should be attempted once in many of the above types of fractures. Occasionally the guarded use of the fluoroscope may aid in approximating the fragments. The promiscuous use of the fluoroscope should not be encouraged. If a thorough trial at closed reduction has failed, open operation should be carried out.

Fixation of the forearm fracture should be by plaster cast extending from the palm of the hand to a point well up on the arm, the elbow being kept at right angles. The forearm should be placed in neutral pronation-supination position except on rare occasions when the fracture fragments cannot be maintained in proper position unless rotation is used. The plaster cast should be applied snugly and fashioned at the hand to give free motion at the metacarpophalangeal joint. If a circular cast is applied, it should be cut on one side to permit spreading during the post-reduction period.

Open reduction of fractures of the forearm is a simple statement and the procedure is often easily performed, but the end results may require prolonged and complex treatment. Some of these complications are shown in Fig. 1, I-J-K. The

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type of internal fixation and its effectiveness depend considerably on the surgeon and the armamentarium he has available for this type of surgery.

Fixation by bone plates has resulted in most of the non-unions encountered in our series. Whether the fracture was open or closed seemed to make no appreciable difference. The difficult and complicated cases are, of course, the ones subjected to open reduction. The bones of the

forearm are actually quite small, and if plates are used they should be of adequate size so that two screws can be placed on either side of the fracture site. The screws should be long enough to be firmly seated in both cortices. The newer type plates with the elongated screw holes are supposed to allow the fragments to approximate and, therefore, should be superior to the old round-hole plates which firmly fix the fragments. Screws and bone plates can be removed safely

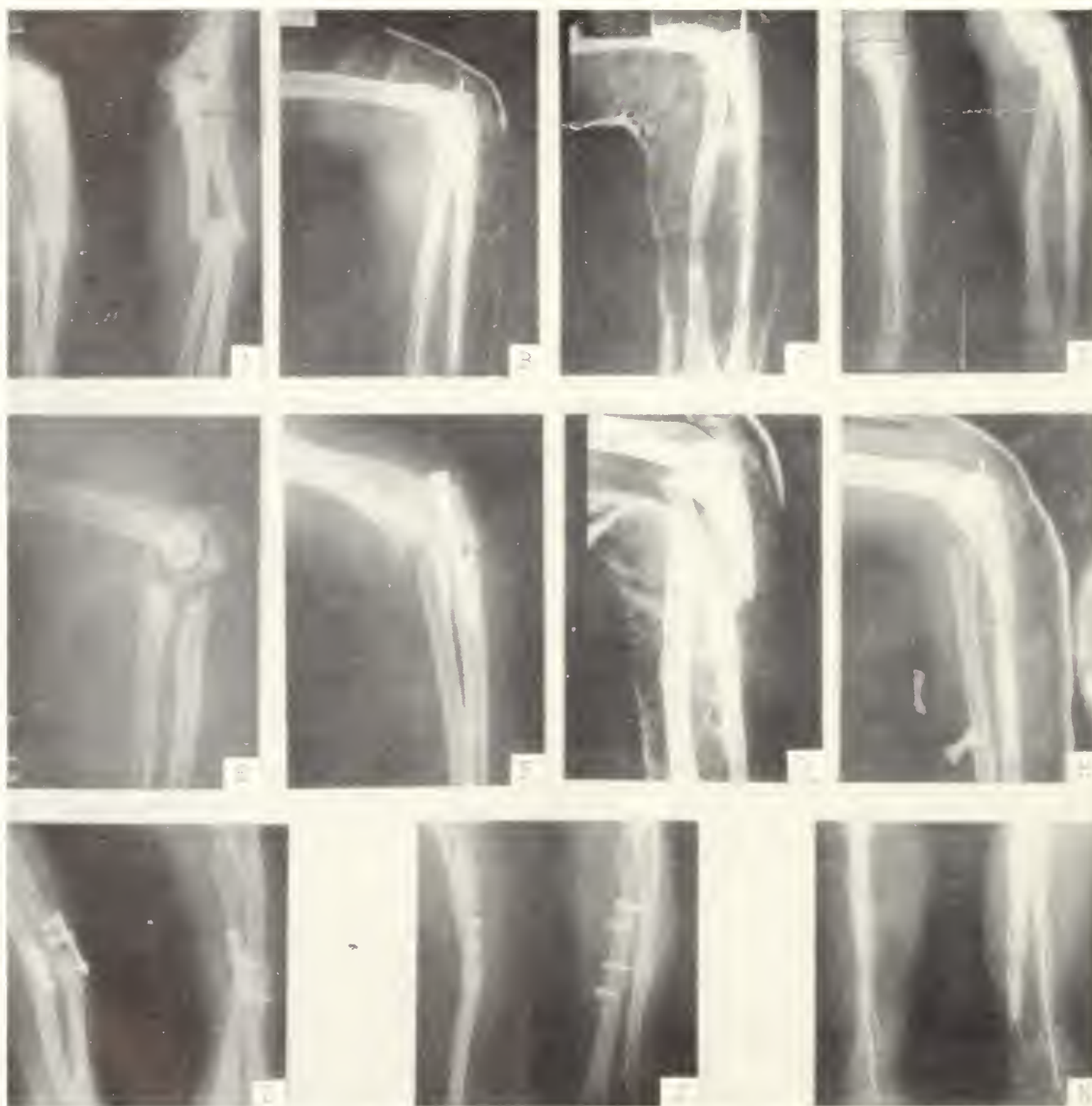


Fig. 1. (A and B) Fracture of both bones of forearm with internal fixation of both bones by intramedullary pins. (C) Fracture of both bones of forearm with intramedullary fixation of ulna; approximation of ends of the radius and fixation with plaster cast. (D) Excellent healing and anatomical alignment with normal function. (E) Comminuted fracture of both bones of forearm at the elbow. (F) Fixation of the olecranon to the shaft by means of a long vitallium screw. Excellent function has resulted. (G) Two-months-old Monteggia fracture. (H) Internal fixation of fracture by Steinmann pin after resection of head and neck of radius. In fresh fractures, the head of radius is replaced and the joint capsule sutured through an anterolateral approach with internal fixation of ulna as illustrated. (I) Inadequate fixation by 2-screw and 3-screw hole plates with wide separation of bone ends resulting in non-union. (J) Union following removal of plates and application of onlay bone graft. (K) Example of intramedullary fixation with onlay grafts with good evidence of healing at six weeks. This was a non-union resulting from compound fractures and plating.

at six to eight weeks and, providing good plaster fixation is continued, the bones should unite.

Intramedullary fixation by 3/32 inch Steinmann pins, .062 Kirschner wires, screws or special intramedullary instruments has certain advantages in that the bone fragments are held in good alignment, the bone ends are held in approximation by normal muscle tone, the pins are easily removed when indicated, and alignment of multiple fractures of one bone is possible. This type of fixation may be used in fractures of either one or both bones. Frequently, in transverse fractures, if the ulna or radius is fixed by an intramedullary pin, the other bone can be placed end-on and require no further fixation (Fig. 1, C-D). Most ulnar fractures have been stabilized by a Steinmann pin, while the Kirschner wire or Steinmann pin is used in the radius (Fig. 1, A-B). Recently we have applied onlay grafts on fresh fractures of the middle one-third at the time of open reduction, as we have found that anatomical reduction produces very little callus—thus prolonged fixation.

The intramedullary pin in the ulna may be placed either through the olecranon or from the fracture site reversely through the olecranon, then drilled back across the fracture site. Usually the latter technique is not necessary. The end of the pin is left protruding from the bone sufficiently for removal. The radius must necessarily be fixed by a pin or wire inserted from the lower end, and the point of entrance dorsal to the styloid between the thumb and finger extensors has proved to be very satisfactory. The Kirschner wire has been used more often in the radius because of its flexibility, making insertion and removal from the radius easier.

Except in certain olecranon fractures a circular plaster cast is applied as previously described. Earlier motion may be anticipated with the intramedullary pins in place. However, if they are removed at two to three months, it is well to guard the part for another three to four weeks with a plaster splint. We have had the experience of forearms angulating following the removal of the pins despite clinical and x-ray evidence of good union—hence the precaution.

Non-unions have been treated by massive onlay cortical grafts of homogenous or autogenous bone with screw fixation (Fig. 1, J). If homo-

genous bone from the bank is used, our period of immobilization has been longer (three to four months). After the preparation of the old fracture site, we have recently treated non-unions by intramedullary fixation, and the grafts have been laid around (barrel-stave) the fracture site, being held by small chromic catgut sutures or by the periosteum and muscle as the wound was closed. The results in these instances seem to indicate that this method of laying grafts about the fracture site as advocated by Phemister and by Steele is excellent, providing proper fixation can be maintained.

Three hundred and twenty forearm fractures have been treated in this clinic in the past three years. Open reduction has been necessary in twenty-four, or approximately 8 per cent. All open reductions have been in shaft or olecranon fractures. There were three non-unions in the series of fresh fractures treated in this clinic, two being compounded in the middle and upper one-thirds, and the third a simple fracture treated by intramedullary fixation of the ulna which resulted in distraction and non-union of an anatomically reduced radius. Six other patients referred to this clinic with non-unions of both bones of the forearm were treated with either massive onlay bone grafts with screw fixation or by intramedullary fixation with onlay grafts about the fracture site. Of these, only one, a long-standing problem, has failed to unite after the use of both of the above methods. This failure was attributed to inadequate intramedullary fixation. Of the nine non-unions encountered, seven had been previously treated by open reduction and plating.

Conclusions

Every fracture of the forearm presents its individual problem. It is felt that in most instances if one trial at closed reduction fails, open reduction is indicated. The precautions in the use of bone plates have been mentioned. The use of intramedullary pins has been stressed and several types of fractures with the results are presented to illustrate their value. Recently, barrel staves of bone have been placed about the fracture site in fresh fractures of the mid-forearm. The treatment of non-unions was briefly outlined, using massive onlay grafts only or intramedullary pinning and onlay grafts without screw fixation.

The Use of Tantalum Gauze Mesh in Repair of Fascia-Deficient Hernias

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SUCCESSFUL surgical reconstruction of any weakness of the abdominal wall is dependent mainly upon the quality of the tissue available for closure of the defect. Where the fascia is attenuated or absent, technical difficulty is increased, and the commonly accepted methods of hernial repair may prove inadequate. Fascial flaps, fascia lata sutures or transplants, preserved ox fascia, periosteal grafts, dermis grafts, and various relaxing incisions are among the many measures which have been employed to aid in bridging such defects. The multiplicity of these procedures attests the fact that none has proved uniformly satisfactory, and recurrences have been disappointingly high.

Tantalum gauze mesh is a finely woven screen of 3 mm. monofilament tantalum wire. The indications for its use are the following: (1) where the fascial defect is of such size that approximation of the edges is impossible, or can be attained only under tension; (2) where the fascia is thin and of poor quality, particularly in recurrent hernias attended by failure of ordinary methods to effect a cure; (3) in the obese individual, where additional stress may be expected to fall upon musculofascial planes of subnormal quality and tone.

Surgical technique involved in the use of this material is not complicated, and it is equally applicable to incisional and inguinal hernia. Operation proceeds to the point where the hernial sac is dealt with by excision and closure or by imbrication. Dissection is then carried outward in all directions until firm supporting fascia or periosteum is reached. The mesh is cut to fit the size and shape of the defect, allowing for projection under the fascial rim with about one centimeter turned under in a double thickness. The

doubled edges of the mesh are anchored to the fascia with interrupted permanent sutures. In inguinal hernia in the male, the cord is brought out through a small, rectangular opening made in the lateral border of the mesh at the level of the internal ring. Ideally, the mesh thus comes to lie between the peritoneum and what remains of the musculofascial layer. Weak, thin remnants of fascia overlying the hernial bulge should not be excised, since these may be overlapped on the mesh as a partial anterior covering, and may contribute towards fibroblast proliferation. A fascia lata free graft sutured over the mesh as advocated by Lam¹ is not necessary and involves a second surgical procedure.

In many cases the abdominal wall will present such scarring and fusion as to render separation of peritoneal and fascial layers impossible, particularly in the large incisional hernia. In such instances, closure of the available tissue in a single layer in the transverse diameter may materially narrow, or completely obliterate, the defect. However, the surgeon should not be deluded by having pulled something together, and tantalum gauze should be anchored as a reinforcing patch over this layer anteriorly, after the technique of Throckmorton.²

The anatomic and physiologic result is a firm, pliable support at first, followed by abundant proliferation of fibroblasts through the mesh to form a dense, strong reinforcement over the hernial defect.

Tantalum gauze is biologically inert, well tolerated by the tissues, and once implanted it should not be removed. Because of pliability, it yields readily to body movements, and there are no subjective complaints except in the occasional case where the mesh has been sutured anteriorly in an individual with minimal overlying subcutaneous fat. There is no interference with healing; in fact, the mesh stimulates the formation of con-

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nective tissue, acting as a trellis which fibroblasts seem desirous of ensheathing as rapidly as possible. The metal work hardens after a period of several months, and fractures of some of the strands may be detected by x-ray, but this is of academic interest only, since by this time the fascial bulwark is complete and solid.

Early ambulation is not contraindicated, and should be encouraged. Subcutaneous serum collection may be a complication in those cases in which dissection has been extensive and large areas of fat have been exposed. In order to obviate this, a small Penrose drain should be left in the subcutaneous space for 48 hours. Tantalum mesh does not increase the incidence of wound infection, nor does it act as a nidus to prolong drainage when wound complications do occur. It presents no bar to subsequent laparot-

omy, since the mesh and its enclosing fascial sheath can be cut with scissors.

Of final importance is the fact that this material has produced good results where other methods of repair had previously failed. In approximately 85 cases reported to date in the literature there has been one questionable recurrence.

Conclusion

Tantalum gauze mesh offers a safe, successful, and technically easy adjunct for the repair of abdominal hernias where fascia deficiency is a dominant factor.

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IN THE SPIRIT OF BENJAMIN RUSH

It was Abraham Lincoln who said: "Public sentiment is everything. With public sentiment, nothing can fail; without it, nothing can succeed."

There are two changing concepts in American medicine today: first, evidence of a changing economic picture; second, in the present social crisis, now looming so large, physicians must tell the public of medicine's situation and what similar changes have led to in other countries.

To put it in another way: It isn't enough to be a good doctor today, *if you want to remain a free doctor*. It is just as important that you be a good citizen—an alert, crusading citizen, taking care of the rights and liberties that came to you and your forebears as part of your American heritage.

This is a refreshing change which is taking place in the thinking of individual doctors. It is a change which reverts to the early pioneer days of Doctor Benjamin Rush, who signed the Declaration of Independence. In those days, the doctor, in many instances, was one of the few educated men in the community. He led the fight for good schools, for proper hygiene and sanitary safeguards—and gave his services in the times when the colonies fought for freedom. In the spiritually sick world of today, the doctor is asked to pick up the gauntlet flaunted by those who would legislate compulsory health insurance for the American people.

The national campaign of education of the American Medical Association will depend for its success upon the doctor becoming, of his own free will, an alert, crusading citizen—teaching the evil and false doctrine of federal compulsory health insurance.

Let us not make the mistake that England did—

negativism and poor public relations. The English public got the impression that the medical profession opposed state socialized medicine for selfish financial reasons. The consequences are now well demonstrated. Full cooperation and demonstration of willingness to effect superior service at the level of large national accounts may save our country from a similar catastrophe.

It is quite evident that the individual physician recognizes the social challenge involving his own professional activities. To date he is doing a grand job in utilizing the helpful services of lay friends of medicine, and, at the same time, extending his usefulness by making available to all the best scientific medical care to be found anywhere in the world.

Mr. Oscar Ewing, Federal Security Administrator, states that existing voluntary health insurance plans are inadequate—covering a mere thirty-two million people with limited hospital care; that it costs too much for most people, and cannot pay its way on lower premiums.

Besides noting that the figure of 32,000,000 is in error and should be nearer 60,000,000, our alert, crusading doctor responds to Mr. Ewing, and states that federal compulsory medicine is sterile; it never invents nor discovers new cures; it can take only by force and coercion what the individual physician can give as a voluntary free service of the people. He adds that American medicine has advanced more during the last twenty-five years than during the preceding century, mostly through methods of precision, specific preventive and curative agents, and in improvements in our hospitals.

Our independent, alert, crusading doctor alone can have the heart of sacrifice, devotion, and love of service.

Without freedom in medicine, the art of healing, itself, disappears.—*New York Medicine*, Sept. 5, 1949.

Chemotherapy and Antibiotics in Urology

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IN a discussion of chemotherapy and antibiotics in urology, no new astounding facts can be brought out. The principles have already been laid before us but, like the facts in the Bible, they stand repeating. This must be a good method, for religion has practiced it and religion of some sort has lived as long as man. Man thinks of certain basic principles having to do with his relation to his fellow man. Repetition of basic principles is just as important in relation to our enemies that would destroy us. Such enemies are infection and disease.

We must be doing better, for our morbidity and mortality figures are less discouraging than they were two decades ago. We had chemotherapeutic agents in years gone by. Oleum santali is an ancient remedy and a fairly effective one. Methenamine was produced less than a century ago. Methylene blue, acriflavine, mercurochrome, gentian violet, pyridium, and hexylresorcinol have all had their trial and enthusiastic supporters. Coupled with normal tissue resistance, the results of their use were not too discouraging. However, man in his inquisitiveness began wanting to know why certain organisms survived and others did not. The advent of the ketogenic diet and mandelic acid began a new conception. The marked acidification of the urine afforded good results in the so-called colon types of infection of the urinary tract. Perhaps the normal acid-forming mechanism has accounted for so-called natural resistance over the previous centuries.

With sulfanilamide a new era opened. Chemotherapeutic attack became logical and effective. As time passed, it was noted that there were complications such as marked crystal formation in the tubules, pelvis, and ureters. Large volumes of fluid were necessary. Alkalinization and good kidney function were essential. Resistant or daughter strains developed when the wrong

or inadequate sulfonamide was used. It was revealed that there was a specificity in the action of these drugs. So the choice of the right one rather than any one places a definite responsibility on the physician who chooses to use these drugs in urinary tract infections.

The coming of the antibiotics did not diminish the clinical importance of the sulfonamides. When penicillin first came and was followed by streptomycin and the train of others, the supposition was that the end of sulfa medication was near at hand. Such has not been the case. On the other hand, a situation was born in which there is a tendency for organisms to fall into groups that respond to more specific medication. This grouping often requires the determination of the sensitivity of an organism to a specific drug, but follows certain rules that are not difficult to learn. Of course, these rules are not 100 per cent accurate, just as many laws do not apply to all situations for which they were made. However, the rules are general and in most cases work quite well.

Knowing urinary infections are often mixed and contain several varieties of organisms, we have come to the realization that a single drug or antibiotic may not serve the purpose. So we have learned to use combinations of sulfonamides, sulfonamides with antibiotics, and antibiotics with antibiotics. This is only a natural course of events. Our failure to realize it previously may have accounted for our failures clinically with what seemed the proper test tube medication.

Just like the three "R's" (reading, 'riting, and 'rithmetic) in school, in the treatment of urinary infections we can apply three *what* questions. The first question we must ask ourselves is "What is wrong?" This implies that we make a thorough study and search for mechanical difficulties. No matter how efficient a urinary antiseptic is, it will work only temporarily if we do not have good kidney function and adequate

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drainage free of foreign bodies. These facts can usually be quickly evaluated by means of blood chemistry and intravenous urograms. When mechanical difficulties have been ruled out or righted and infection is still present, we must ask ourselves the second question, "What organism is responsible?" Identification of the offenders is our first step toward treating the condition intelligently.

Now, up steps the practitioner located in a small center or using a hospital laboratory loaded down with routine tests. He finds that detailed bacteriologic studies and the sensitivity tests mentioned above are impossible or too expensive. Of course, all of these tests are necessary and wise in complicated situations for a complete catalog of the offenders, but are often of academic interest. On the other hand, the Gram stain is an easy office procedure. It has been done many times by every medical student. This stain will sort out the Gram-negative from the Gram-positive organisms and will identify the cocci from the bacilli. Basically, this is what we need to know.

Now is the time to ask the third question, "What drug is needed?" Let us construct a

chart using the organisms commonly found infecting the urinary tract and the medication we have available. Competent laboratory investigators have determined their sensitivity to the sulfonamides and antibiotics. Various strains may not run true to form even after these tests are made. The behavior to staining by the Gram method and learning whether there is a coccus or bacillus present are the important factors. By staining, we find that the staphylococci and the streptococci commonly found in the urinary tract are Gram-positive organisms. So the "S's" have it: *Staphylococcus albus*, *Staphylococcus aureus*, *Streptococcus hemolyticus*, *Streptococcus faecalis*, and *Streptococcus viridans* (see Fig. 1).

Experience has shown that sulfathiazole and sulfadiazine have been the drugs of choice against this group. Slightly larger doses than the usual routine ones may be needed for *Streptococcus faecalis* infections. Sulfathiazole seems to have preference here and is used in an acid rather than the usual alkaline urine.

However, the sulfa drugs are versatile and being versatile they are not specialists. Therefore they do a job but not with the specificity noted in the antibiotics. Having set down the

Urinary Tract Infections													
Organisms and Drugs													
	Gram +						Gram -						
	Staph. Albus	Staph. Aureus	Strep. Hemol.	Strep. Faecal.	Strep. Virid.		Esch. Coli.	Ps. Aero.	Hem. Infl.	Prot. Vulg.	Gon.	Aerob. Aerog.	Myc. TB.
Sulfathiazole	⊕ ^{AI}	⊕ ^{AI}	+ ^{AI}	⊕ ^{AI}	⊕ ^{AI}			⊕	⊕		⊕ ^{AI}		
Sulfadiazine	⊕ ^{AI}	⊕ ^{AI}	+ ^{AI}	⊕ ^{AI}	⊕ ^{AI}			⊕	⊕		⊕ ^{AI}		
Sulfacetimide							⊕						
Sulfathaladine							⊕						
Sulfasuxidine							⊕						
NU 445							⊕			⊕			
Penicillin	+ ^N	+ ^N	+ ^N	+ ^N	+ ^N						⊕ ^N		
Streptomycin	⊕ ^{AI}	⊕ ^{AI}	⊕ ^{AI}	⊕ ^{AI}	⊕ ^{AI}		⊕ ^{AI}	+	+	⊕ ^{AI}	⊕ ^{AI}	⊕ ^{AI}	⊕ ^{AI}
Bacitracin	+ ^{PR}	+ ^{PR}	+ ^{PR}	+ ^{PR}	+ ^{PR}		⊕ ^{AI}	-		-		+	
Chloramphenicol							⊕ ^{AI}	+		+		+	
Mandelic Acid							+ ^{ac}	+ ^{ac}		+ ^{ac}		+ ^{ac}	
Methenamine							+ ^{ac}						
Combinations													
Sulfathiazole } Sulfadiazine }	⊕	+	+	+	+		+	-		+		⊕	
Sulfacetimide } Sulfadiazine }	+	+	+	+	+		+	-		+		⊕	

Action ⊕ good, + fair, - none PR-Penicillin Resistant
Ideal Urinary Reaction-RI, Alkaline, Ac, Acid, N, Neutral

Fig. 1

Gram-positive germs all beginning with "S" horizontally on the left of our chart (Fig. 1), let us continue to the right, listing the Gram-negative organisms commonly found in the urinary tract. They are: *Escherichia coli*, *Pseudomonas aeruginosa*, *Hemophilus influenzae*, *Proteus vulgaris*, *Neisseria gonorrhoeae*, and *Aerobacter aerogenes*. We find that sulfathiazole and sulfadiazine have a fair degree of efficiency in combatting three of these, namely, *Pseudomonas aeruginosa*, *Hemophilus influenzae*, and *Neisseria gonorrhoeae*. This versatility perhaps accounts for the good results formerly obtained by hit-and-miss methods and has been a godsend on many occasions. We can place the reactions on our chart in the places indicated, but always remembering that the potent point for these sulfa drugs is to the left of the mid-line, namely, against the Gram-positive cocci and naturally always beginning with "S."

Because of several factors, sulfacetimide has been championed as one of the better sulfonamides. It is a highly active, absorbable, and soluble compound excreted in the urine in high concentration. It is only one-fifth as toxic as sulfadiazine, one-seventeenth as toxic as sulfanilamide, and 115 times as soluble as sulfadiazine.⁶ It does not produce urinary concretions. It has been shown to have exceptional bacteriostatic activity against *Escherichia coli*,⁸ and in a concentration of 200 mg. per cent, easily obtainable in the urine, was bactericidal. So it assumes the next place in line as we set down the drugs vertically on our chart (to the left in the order named). It is not the only sulfonamide observed having usefulness in the treatment of infections of the *E. coli* variety (Fig. 1). Sulfasuxidine and sulfathalidine have a place here. The method of action is thought to be different from that of sulfacetimide.¹ Very little of the sulfathalidine is absorbed and almost all is excreted by way of the bowel. During this process, however, it practically sterilizes the bowel. It is believed that the colon organisms reach the urinary tract by means of the lymphatics from the bowel. When the bowel is freed of organisms, the lymphatics are clear. This allows the urinary tract to regain its natural resistance to throw off the infection present.

A new sulfonamide, at present called NU 445, has recently had a trial. It also has value in the treatment of infections of the *E. coli* and *P. vul-*

garis types. The preparation is tolerated well and is free from the threat of crystalluria. However, it is not a cure-all and is definitely considered as only another adjunct to our armamentarium, being useful when others are not so effective.

One cannot close a discussion of the sulfonamides without calling attention to the gonococcus. This organism, the one Gram-negative coccus, first lent itself to treatment with the sulfonamides. Although resistant strains developed, it is still a popular method of treatment. Of course, this furnishes a point at which we usher the antibiotics into the problem and add them to our chart.

Penicillin

Penicillin, the first antibiotic to offer us hope, has proved to be an anchor on which we rely. Perhaps its real virtue is in the attack it makes on the secondary invaders and on the fact that organisms do not early develop resistance to it. It is shown on the chart in almost the same situation as sulfathiazole and sulfadiazine in its usefulness on the organisms to the left, the Gram-positive group. The gonococcus is the only Gram-negative organism on which it is effective. Clinically it often has the extra potentiality to make temperatures fall and urine clear. It has been said that the penicillinase produced by the colon organisms lessens its usefulness. I feel that this is true only in the oral administration and doubt whether this method of administration has a real place in the treatment of upper urinary tract infections, although it can be used by this route in the treatment of gonorrhea. It is true that most urinary tract infections are of the Gram-negative variety, but one must remember that they are rarely pure cultures. Gram-positive organisms occur often enough to make penicillin have a definite place of usefulness. Its dosage of 300,000 units daily has been fairly well established. Divided doses rather than single dose methods function slightly better in urinary infections.

Streptomycin

If streptomycin had been discovered first, it may have been heralded as the ideal urinary antiseptic, since most urinary tract infections fall into the Gram-negative group. As it is, it can be said to complement the field of usefulness of penicillin and the sulfonamides. What more could be asked than an excellent antibiotic effec-

tive on the Gram-negative organisms to follow or precede those effective on the Gram-positive variety? Penicillin is relatively nontoxic and bacterial resistance is not developed easily. These are the two chief obstacles in the use of streptomycin. The toxicity develops fairly early and consists of an impaired function of the vestibular portion of the eighth cranial nerve. It appears that this toxicity is a result of maintained plasma concentration rather than occasional peak concentration. Visual compensation develops in most patients and a great majority suffer no lasting inconvenience. The dosage now² has been altered to give the sharp peak rise rather than the maintained dosage level. Where previously 0.3 Gm. doses were given every four hours, the plan thought wise now is to administer 0.5 Gm. every twelve hours. As noted in the chart, streptomycin has its maximum efficiency in an alkaline urine and on the Gram-negative organisms to the right of the mid-line.

Resistance to streptomycin is especially serious in urology. Resistance, like toxicity, may develop early. Therefore, if the drug is given when obstructions, foreign bodies, or other complicating pathology is present, rather than after it has been righted, the danger develops that the drug will be ineffective after surgery, when really needed. This brings us to the real necessity of making sensitivity tests more with the use of this drug than any other. Some organisms (strains) are known to become dependent on this drug for growth because of a developing resistance. This suggests serious consequences that may develop from its indiscriminate and careless use. Failure to recognize the drug's limitations could tend to nullify its widespread value in infections not amenable to other types of therapy.

Streptomycin in Tuberculosis.—During the past year there has become available, cheaper, purer, and less toxic streptomycin. It remains the only antibiotic of proved value in the treatment of tuberculosis. Before the advent of streptomycin, tuberculosis of the urinary tract was accompanied by a particularly bad prognosis. This, of course, was due to the fact that tuberculosis might well be in other organs of the genital or urinary tract and particularly in the other kidney.

In discussing tuberculous lesions in the kidney, we must think of two kinds: first, those with small ulcerative lesions, and second, those with large caseous or fibrocaseous lesions. The

first group are those seen early in which the lesions cannot be detected by x-ray but which free tubercle bacilli into the urine recovered from the kidney. These cases are picked up only after careful urologic study of patients usually with obscure bladder symptoms or of patients who have already had one kidney removed for tuberculosis. Any tuberculous patient who begins to show albuminuria or pyuria should be suspected of having early ulcerative renal lesions. In this type of case a high percentage (five out of six)² will show a disappearance of the tubercle bacilli from the urine after streptomycin therapy, and the urine specimens tend to remain clear.

However, in the caseous or fibrocaseous types, the chances of clearing the urine are not good. Also, there is little chance of any changes occurring in the pyelographic outlines. This is not surprising in view of the firm consistency of the kidney, which would prevent the cavity from collapsing even if improved. At present, when the condition is unilateral, we believe that these are the patients best subjected to nephrectomy in conjunction with streptomycin therapy and sanatorium care.

Rather recently the threat of stricture formation has come into the problem of streptomycin treatment of ureteral tuberculosis. There have been observed a fair number of cases in which narrowing with obstruction has occurred as healing resulted. Future observation alone can tell what will really happen.

Superficial cystitis and ulcerations have been seen to heal in six to eight weeks under this therapy. The disappearance of symptoms is striking. With the lessening of the frequency of urination, bladder capacities increase. When the urine from the kidney remains negative to culture, the bladder lesions stay healed; but if the kidney lesions again flare up, bladder symptoms usually reappear.

Few or no changes are noted in the prostate, seminal vesicles, or epididymides. Nodules in the prostate seem to be uninfluenced by the therapy. Draining sinuses from a discharging caseous epididymis usually do not heal, but skin sinuses where the caseous focus has been removed show rather prompt response to its use. The fibrocaseous character of the prostatic nodules and the chronic epididymitis probably account for the failure of this therapy. It has been noted that with streptomycin acute epididymitis due to tuberculosis runs a similar prolonged

course, but does not break through the skin of the scrotum as so often happens when untreated.

Aureomycin

Aureomycin gives promise of being a versatile antibiotic. It is a potent factor in vitro against many Gram-negative and Gram-positive organisms. When it has been determined that an infection is resistant to penicillin, streptomycin, or sulfonamides, or patients exhibit severe and uncontrollable sensitivity to these drugs, it is advisable to try this drug. It has been especially useful in infections caused by the coli-aerogenes group which are Gram-negative. It is believed that it will be effective in Gram-positive infections that are not penicillin-resistant.

Oral therapy is preferable and it is promptly absorbed, giving immediate high concentrations in the blood and tissues. Originally, 25 to 30 mg. per kilogram of body weight in divided doses was advocated. However, it seems that 250 mg., if given four times a day, seems to be sufficient. The daily doses are suggested for periods of from five to fourteen days as judged by the clinical response. Nausea and vomiting, noted at times, is said to be less with better refining of the product.

Chloromycetin

Another antibiotic awaiting real clinical trial is chloromycetin. It has been shown to be useful in small groups of cases with urinary tract infections (due to *Escherichia coli*, *Aerobacter aerogenes*, *Pseudomonas aeruginosa*, and *Bacillus proteus*). Urine specimens have become free of organisms in one to three days after administration of 2 to 3 grams of chloromycetin daily. It is advised that treatment be continued with 0.25 gram three or four times daily for five to seven days after the urine has become clear by culture.

Combinations

Recently, due to the work of Lehr,^{4,5} it has been shown that sulfonamides are independently soluble, so that it is advisable to administer fractional quantities of two or more compounds with consequent lessening of the likelihood of renal precipitation. These in combination have chemotherapeutic activity corresponding to the total sulfonamide dosage used. One of the first of these was a combination of sulfathiazole and sulfadiazine. The results following the use of these brought forth others with varying results. One of the newest is sulfacetimide combined with sulfadiazine. This combination gives sul-

facetimide that is highly soluble and offers high urine concentration of the drug, while sulfadiazine gives high activity and high blood concentrations. This mixture presents an attack on the pathogen in both directions. Seneca⁶ believes that as routine management this is the safest combination and seems likely to be the most effective. However, he does advise sensitivity tests using various sulfonamides and combinations in different dilutions on the specific organism in the individual case. Turbidity readings are made and the proper drug chosen even though the organism is not identified. Where the germs are identified, it is noted that there is broad overlapping of the respective fields even though the compounds have a preferential field of action. The combinations tend to preserve the range of action of the separate compounds and combine their ranges in general. This, of course, brings us to the possibility of using penicillin and streptomycin in combination or with some of the chemotherapeutic agents. It would seem that there is no real reason why this cannot be done. I do not believe there is any real evidence to prove that one interferes with the action of the other.

Conclusions

The chemotherapeutic and antibiotic agents fall into groups as to their usefulness. The organisms frequently infecting the urinary tract fall into groups that are likely to be affected in a specific manner by one of the agents above. At present the Gram stain is the best method of determining quickly and simply which medication to use. If intelligent study of the cases and careful choice of the agent are made, excellent clinical cures will result. It would seem as time goes on that better and more specific agents will be available, but the sensitivity of the organisms must be studied carefully in order to get the best results.

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The Treatment of Acute Coronary Occlusion with Anticoagulants

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LESS than a decade since the isolation of dicumarol by Link,¹ the use of anticoagulants has become an established procedure in the treatment of thrombo-embolic disorders. An extensive clinical evaluation by Wright² of the use of this drug is being sponsored by the American Heart Association. Many other clinics have been experimenting with its use so that several fundamental principles are now accepted. We are reporting 170 patients treated with anticoagulants. Among these were 13 deaths (7.6 per cent) and one with thrombotic complications (0.59 per cent). This was controlled by 120 patients as similar as possible to the above except for no anticoagulant therapy. Twenty-seven (22.5 per cent) of these died and in 14 patients (11.7 per cent) embolic complications developed.

Dicumarol should be administered only to patients in a hospital staffed and equipped to make daily prothrombin determinations and having a blood bank with an adequate supply of whole blood. Prothrombin activity is measured either on whole or diluted plasma and reported in seconds or per cent of normal value. The clinician should familiarize himself with all aspects of his chosen method of prothrombin determination and adhere strictly to this routine. None of these methods in present use is free from criticism. Our laboratory uses the Quick method on undiluted plasma. The value of controls is between 12 and 16 seconds, and the therapeutic level is prolonged to about three times the normal.

Dicumarolization of the average adult requires the oral administration of 300 mg. the first day, 200 mg. the second day, and continued maintenance according to the daily prothrombin level and clinical response of each patient.

We began this study using only dicumarol, but since the effective concentration of dicumarol is not reached for 48 hours, the coagulability of blood is reduced during this period immediately following an acute coronary occlusion by the simultaneous administration of heparin.

Bleeding is the only clinically proven toxic effect. It is controlled by the rate of administration of the drug, the use of large doses of synthetic vitamin K, and, in acute emergencies, by transfusions of fresh whole blood.

The optimal length of treatment has not been determined and among clinicians it has varied from two to six weeks. In an attempt to forestall acute coronary occlusion, Sterling Nichol has kept 68 patients on continuous dicumarol therapy for periods ranging from three months to five years. Many of these patients experienced less cardiac pain during treatment.

Contraindications to the use of dicumarol are related to liver disease, especially in the presence of vitamin K deficiency, severe hypertension, ulcerative lesions of the gastro-intestinal tract, severe renal failure, and blood dyscrasias with a bleeding tendency.

Because of the fact that it is impossible to predict when a coronary vessel may become occluded, such an accident can rarely be prevented by anticoagulant therapy. We feel confident, however, that thrombosis of smaller branches can be prevented from extending by the early use of anticoagulants. It has been our experience that more than half of the patients admitted to our services have had attacks of mild or moderately severe pain before the overwhelming attack developed which necessitated hospitalization. Clinical and experimental evidence indicates that such treatment has no influence on the size of the existing lesion. Considering the arteriosclerotic changes in some coronary arter-

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ies, it is not surprising that further occlusions occur even in the presence of an adequate anticoagulant. However, the use of an anticoagulant is physiologically sound in preventing the complications due to the extension of pre-existing thrombi, the development of new thrombi in other branches, in the formation of mural and thebesian thrombosis and phlebothrombosis of peripheral veins, a fertile source of lung emboli, and thus minimizes embolic tendencies. Once the drug is discontinued and the prothrombin concentration approaches normal, the underlying degenerative changes are still present in the vascular system and there is no barrier to subsequent attacks.

During the period June 1, 1946 to June 1, 1949, there were 237 patients with clinically proved acute coronary occlusions admitted to the Cardiac Service of Mercy Hospital. Everyone of these patients, regardless of the severity of disease, was immediately placed on anticoagulant therapy. Forty-five were admitted in such serious condition that they died in 72 hours and were excluded from the present study, as were all in the control group dying within the same time limit. Of the 192 patients who survived 72 hours, 170 had adequate treatment, four of whom were treated in two attacks each. Seven patients were not treated because the mild nature of their symptoms masked the diagnosis. Fifteen were discontinued either because of their unwillingness to submit to daily prothrombin determination or because of complications such as severe liver disease, acute peritonitis from a perforated diverticulum, carcinoma of the larynx, active peptic ulcer, or severe hypertension. Of the 170 fully treated cases, 13 (7.6 per cent) died during hospitalization of such complications as congestive failure (3), pulmonary edema (2), sudden death while under treatment (3), diabetic hypoglycemia complicating a third coronary occlusion (1), high-grade aortic stenosis (1), multiple pulmonary infarctions present on admission (2), and a hypertensive 43-year-old man with his third coronary occlusion died of a massive cerebral hemorrhage when his prothrombin concentration was 35 per cent normal.

Thirteen of these patients had embolic complications on admission. Two died soon after admission with multiple pulmonary emboli. One man with a popliteal embolus died of congestive failure, and a second with a popliteal em-

bolus refused dicumarol. This latter individual died some weeks later from thrombosis of the innominate artery. The remaining nine had no further emboli after initiation of anticoagulant therapy and subsequently they recovered. A 57-year-old man had a second vascular occlusion while his prothrombin concentration was 45 per cent of normal value. This nonfatal thrombotic complication is the only such occurrence in this series (.59 per cent).

The toxic manifestations of dicumarol have not been a serious problem in the management of these patients except in two instances. The majority of hemorrhagic episodes including oozing from the gums, mild hemoptysis, bleeding hemorrhoids, slight to gross hematuria, and a small conjunctival hemorrhage were of a mild nature.

We believe that massive hemorrhage from dicumarol therapy contributed wholly or in part to the deaths of two patients. One of the patients who died of pulmonary edema had experienced a severe gastro-intestinal hemorrhage the previous day. The other dicumarol death was that of the man with hypertension who had a cerebral hemorrhage during the fourth week of treatment.

More severe gastro-intestinal bleeding or persistent gross hematuria disappeared if the drug was withheld for a day or two and then resumed at a lesser concentration or on the intravenous administration of 65 mg. of hykinone (synthetic vitamin K). Two patients underwent successful major surgery while their prothrombin levels were being kept in therapeutic range by dicumarol. Each of these received 500 cc. of fresh whole blood at the time of operation. One of these patients had a resection of a gangrenous portion of intestine due to volvulus and the other was a man who recovered from an appendectomy for acute suppurative appendicitis.

The control group of 120 persons comprised all cases of acute coronary occlusion admitted to the Cardiac Service of Mercy Hospital from June 1, 1944 to June 1, 1946. Insofar as possible these patients were similar to the test group in all respects except for the omission of anticoagulants. Of these 120, there were 27 deaths from all causes (22.5 per cent).

Embolic complications developed in 14 patients (11.7 per cent)—pulmonary (5), brain (5), popliteal (1), mesenteric (2), bifurcation of aorta (1). The life of this last patient was

saved by embolectomy and he remains well four years later.

In attempting to assess the value of this treatment, one has to refrain from undue optimism and should maintain a healthy skepticism towards the statistical results. The mortality figures of various groups during the past 20 years range from a high of 50 per cent by Levine⁸ in 1929 to a low of 5 per cent by Masters⁹ in 1936. This latter result was achieved in a selected group of 120 private patients in their first attack of coronary occlusion. Our group¹⁰ reported in 1935 included patients seen in office, consultation, as well as in hospital practice. Many of them were less seriously ill than the patients in the two groups now being reported.

The figures for thrombo-embolic complications also vary widely. It is well known that the majority of patients dying with heart failure will have at autopsy lung infarcts which were not recognized clinically. It is a matter of interest that the incidence of embolism in a group of 200 patients whom we had seen between the years of 1928 and 1931 was 10 per cent, almost the same as in the control group of the present report. If this report has any merit, it seems to lie in the fact that the criteria for diagnosis were the same in the control and in the treated groups. All of the patients were seen and treated by one individual service and treatment was similar in every respect save for the use of anticoagulants.

Summary

We believe that the use of anticoagulants in the treatment of acute myocardial infarction is a valuable therapeutic measure. The mortality in the treated group of 170 patients was 7.7 per cent. The mortality in the control group was 22.5 per cent. Thrombo-embolic complications were reduced from 11.7 per cent in the control group to approximately 1 per cent in the treated group.

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DIVIDE AND CONQUER

The *Wall Street Journal* tells the story of the physician down in North Carolina who asked his friend, a real estate man, to attend a meeting on socialized medicine. The friend refused and the doctor said:

"But aren't you alarmed at the threat of socialized medicine?"

"Sure I am," said the real estate man, "but where were you doctors all these years when the real estate men were fighting against socialized housing?"

The doctor had no answer.

The *Wall Street Journal* goes on to warn:

"The doctors fight socialized medicine, the real estate men fight public housing, each business or industry fights its own battles against government encroachment—but never together."

Divide and conquer is an old and well-proven strategy that swallows its victims, one by one, before they know they are bitten.—*New York Medicine*, Nov. 5, 1949.

HIGHLY SUCCESSFUL RURAL HEALTH CONFERENCE

The fifth annual AMA Conference on Rural Health in Kansas City drew more than 500 medical and lay leaders concerned with providing medical care to small communities.

The relating of experiences all over the country showed that the rural health problem is steadily being solved through cooperative community efforts. That is the American way—through unity, not uniformity.

It was the consensus of the conference that (1) existing and proposed facilities should be coordinated and integrated for an effective and fully utilized program; (2) an intensified educational program is needed to acquaint people with facilities available to them in order to prevent the construction of unneeded hospital capacity; (3) tax funds should be used to provide medical care only in cases where an individual cannot provide for such care; (4) greater efforts should be made to enroll rural people in prepayment medical care plans.

The Management of Imperforate Anus

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THE management of imperforate anus is quite different in the two sexes. Most female infants with imperforate anus have a concomitant rectovaginal fistula and can pass stools through the vagina. Occasionally the rectovaginal fistula requires dilatation once or twice, but other than that, definitive operation can be postponed for a matter of months. We elect to do the procedure of closing the fistula and establishing an anus at about three months of age.

The operation can be done later, but parents are relieved to have it accomplished early, and we have seen extensive dilatation of the colon in children first seen by us at the age of three, four, or five years with an imperforate anus and uncorrected rectovaginal fistula.

In the male, the problem of imperforate anus is that of complete intestinal obstruction, often complicated by the presence of a fistula between the rectum and the urinary tract, usually the bladder, but occasionally the urethra.

Although these infants have complete intestinal obstruction, they are not the urgent problem that is presented by complete intestinal obstruction from other causes. One has sixty to seventy-two hours after birth during which operation may be carried out without undue risk from the standpoint of neonatal physiology. After the fourth day of life, however, the mortality increases. Moderate delay in surgery is essential, actually, if one is to assess accurately the site of lowest descent of the colon.

By using the techniques of Wangenstein and Rice or that of Rhode, serial scout films of the abdomen taken six to eight hours apart will reveal the point of maximal descent of the colon. The usual teaching concerning the method of management of imperforate anus is to divide the patients into two groups: (1) those whose

colons can be exteriorized through the anal dimple from below, and (2) those in whom such a procedure is not possible. In the latter group sigmoid colostomy is usually performed. The maximal distance between the colon and the anal dimple permitting the perineal approach is usually given as two centimeters.

At the Children's Hospital of Philadelphia it has not been our custom to follow this plan. In the first place, we have been called upon to treat a number of anal strictures in patients whose congenital imperforate anus was previously treated by a difficult perineal approach. Hence, we have come to use the perineal approach only if such a procedure can be carried out without excessive trauma and damage to the nerve supply and blood supply—usually a distance of 1.5 centimeters or less between the colon and anal dimple.

Second, we have tried to avoid colostomy whenever possible, reserving it for patients weighing less than five pounds, or for those with major concomitant problems contraindicating more extensive surgery than a colostomy.

Our procedure of choice in patients in whom the colon is too high to conveniently reach from below is a combined abdominoperineal approach. Having once established the fact that such a procedure will be necessary, the patient is placed on gastric suction drainage and is prepared for surgery by having a cut-down for blood transfusion placed in the right ankle. The child is then prepared on the operating table so that it is possible to approach both the abdomen and the perineum through sterile drapes by keeping the left leg in the operative field. The abdomen is opened by means of a transverse incision placed between the umbilicus and the symphysis pubis on the left and the blind end of colon is found and is exteriorized. At this time the fistula, if any, is repaired. If the colon contains large amounts of gas and meconium, it sometimes is necessary to remove such by making a small hole in the end

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From the Children's Hospital of Philadelphia and the Harrison Department of Surgical Research, School of Medicine, University of Pennsylvania.

of the blind loop of bowel. The contents of the bowel in the first several days of life at this low level are almost always sterile and one need not fear unduly the results of opening the bowel under these circumstances.

A small nick is then made in the skin of the perineum right over the anal dimple and this aperture is enlarged by means of a mosquito hemostat, then a larger hemostat, and finally a Kelly clamp which is passed up through the perineal body until it perforates the peritoneum in the true pelvis. A finger is then passed through the newly formed canal and the blind loop of colon is exteriorized by bringing it through the canal thus made in the perineum and out through the anal dimple. Several centimeters of colon are left hanging outside of the anal skin, inasmuch as it is difficult to know where the line of demarcation will establish itself. This excess of mucosa can be trimmed off in a week or ten days.

In those cases in which colostomy must be resorted to because of a small baby or concomitant disease, we find it ever so much more practical to do such a colostomy in the transverse colon. This then permits us to carry out the pull-through procedure just described at some later date and then to close the colostomy.

With the use of chemotherapeutic agents and antibiotics, colostomy in infants does not carry

the forbidding mortality of a few years ago. If safe and effective anesthesia is difficult to maintain, it would seem that the child's best future would be served by the use of a transverse colostomy as a temporary procedure, and a later abdominoperineal or pull-through procedure when and where facilities for specialized anesthesia, surgery, and after-care are available.

In summary, then, at the Children's Hospital of Philadelphia we believe that the perineal approach should be limited to patients with a distance between colon and anus of 1.5 centimeters. Colostomy should be limited to patients of premature weight or those in whom concomitant problems contraindicate more extensive surgery. Such a colostomy should be placed in the left half of the transverse colon in order to leave the sigmoid for later definitive surgery.

The combined abdominoperineal pull-through procedure used on the remainder of patients with imperforate anus has proved to be safe and effective. In sixteen such newborn patients we have lost but one, and in those now old enough to assess the anus appears to be continent except during bouts of diarrhea.

Inasmuch as transverse colostomy no longer carries a high mortality, it is suggested that such a procedure be carried out initially if circumstances do not permit immediate definitive operation.

GO EASY WITH ACTH

Every discovery, every advancement made by science in its endless war against disease is hailed with profound thanks by the physician. He follows the progress of research eagerly, always hopeful that new medicine and treatment will aid him in serving his patients.

In recent months, we have heard a great deal about ACTH and cortisone, which have been widely publicized as cures for arthritis and, as a result of such premature publicity, have sent hope soaring in the hearts of countless sufferers.

There is little doubt that ACTH and cortisone are to play an important part in curing the agonizing, crippling disease of arthritis. But it must be pointed out that much more will have to be learned about these drugs before they can be used safely to treat arthritis and other conditions. And the medical profession has a clear-cut duty to warn the public that the drugs and their real action in the body need a great deal more study before their advantages and disadvantages can be

determined. These drugs are in very limited supply and are available only for research purposes. Studies are being made in selected hospitals of the country to find out just what these hormones actually do in the human body. In some instances ACTH has checked arthritis but caused diabetes; when the treatment was withdrawn the diabetes disappeared and the arthritis returned. ACTH has brought favorable response in some cases of rheumatoid arthritis, but failed to prevent the return of symptoms in spite of increasing dosages; in other patients ACTH has improved the arthritic condition and the improvement has been retained even after treatment stopped. In still other cases treatment had to be stopped because hairiness developed.

We look with great hope toward the day when the "wonder drugs" may prove to be truly life-savers. But meanwhile we should use great caution in our approach to the drugs, and we are obliged to discourage, temporarily only we hope, the public from expecting too much of them.—*Philadelphia Medicine*.

Acute Obstructive Laryngitis in Children

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NEARLY every physician who has practiced five years or longer has seen a child die from acute obstructive laryngitis. It is not a pleasant experience. These deaths are now preventable if the correct diagnosis is made early and if proper treatment is utilized.

Acute obstructive laryngitis in children may be classified in the following manner:

1. Acute supraglottic edematous laryngitis
(Acute epiglottitis)¹ (Edematous septic laryngitis) (Influenzal laryngitis) (Edema of the glottis)
2. Angioneurotic edema
(Supraglottic allergic edema)
3. Laryngeal diphtheria
(Membranous croup) (True croup) (Diphtheritic croup)
4. Subglottic allergic edema
(Spasmodic croup) (Spasmodic laryngitis) (False croup) (Catarrhal spasm of the larynx)
5. Acute laryngotracheobronchitis
(Subglottic laryngitis) (Nondiphtheritic croup) (Virus croup)^{2, 3}
6. Foreign body in the larynx or upper trachea

Each of these forms of acute laryngeal obstruction causes the classical symptoms of retraction of the soft tissues above the clavicles and in the epigastrium with each inspiratory effort, but the urgency of treatment and type of treatment depend on the disease present. Prompt and accurate diagnosis is imperative. It is not safe practice to assume that diphtheria is the cause, give antitoxin, and then wait to judge its effect.

Croup has been defined as any affection of the larynx or trachea accompanied by a hoarse ringing cough and stridulous, difficult breathing. I think we should drop the term "croup" because

it is an inaccurate, misleading, non-descriptive diagnosis. Its use is misleading because it is applied to at least three pathologic conditions which produce a croupy cough. Direct laryngoscopy and bacteriologic study permit us to distinguish between diphtheria, subglottic allergic edema, and acute laryngotracheobronchitis. I suggest using the term "obstructive laryngitis" to replace the word "croup." I would retain the term "croupy cough" to describe the type of cough produced when there is subglottic swelling.

Acute Supraglottic Edematous Laryngitis (Acute epiglottitis) (Influenzal laryngitis)

Acute supraglottic laryngitis is a term applied to an inflammation involving chiefly the epiglottis and aryepiglottic folds. It is a clinical entity and should be distinguished from acute laryngotracheobronchitis. This infection develops with *great rapidity*. Within a space of 4 to 24 hours, the child may have sufficient dyspnea to require tracheotomy.

Under this heading I am considering only those inflammations which begin in the tissues surrounding the upper laryngeal orifice and exclude those which are secondary to inflammation elsewhere, such as cellulitis of the neck and Ludwig's angina. Direct laryngoscopy shows intense redness and swelling of the epiglottis and aryepiglottic folds. In some cases the epiglottis resembles a bright red cherry. Often the red, swollen epiglottis can be seen by depressing the tongue. This is the clinical picture frequently diagnosed acute epiglottitis or influenzal laryngitis. H. influenzae, Type B, is often, but not always, the infecting organism.

The clinical picture of supraglottic laryngitis is often diagnostic of the type of obstruction present. Older children will complain of pain in the throat. Swallowing is difficult, so that saliva may drool from the mouth. These symptoms do not accompany subglottic laryngitis. There is a

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coarse, fluttering sound in the pharynx, chiefly during expiration, due to vibration of the swollen aryepiglottic folds, but a croupy cough is *not* present. Respirations are apt to be slow because the patient has learned that a rapid or forceful inspiration sucks the edematous aryepiglottic folds into the larynx and thus increases the dyspnea. Pale cyanosis is often present. The shock-like picture described by some authors is, in my opinion, due chiefly to anoxia. I say this because it clears up immediately after tracheotomy. Oxygen is *no* substitute for tracheotomy. For emphasis, I repeat—tracheotomy may be necessary four hours after the onset of the first symptom. Hence, even prompt treatment with dihydrostreptomycin will not avoid tracheotomy in some cases. Croupy cough is not present because this type of cough is produced only by subglottic swelling. True hoarseness is not caused by supraglottic laryngitis. These children insist on sitting up and tend to extend the head in order to increase the airway.

Our treatment program includes dihydrostreptomycin (20 mg. per pound of body weight per day) given intramuscularly in divided doses every six hours, and penicillin (50,000 units to 100,000 units) intramuscularly every three hours. All patients have responded promptly, so we have not used serum or sulfadiazine since streptomycin has been available.

There was only one death in my series of 16 cases, and that was due to delayed tracheotomy. Seven patients required tracheotomy.

Angioneurotic Edema

(Supraglottic allergic edema)

Angioneurotic edema involving the supraglottic structures can develop with great rapidity and presents exactly the same clinical picture as that caused by acute supraglottic laryngitis, but direct laryngoscopy shows a pale watery edema of the epiglottis and aryepiglottic folds in contrast to the fiery red edema seen when the obstruction is due to acute supraglottic laryngitis. Angioneurotic edema will usually respond quickly to parenteral administration of epinephrine and ephedrine, but in one case it was necessary to insert a bronchoscope and leave it in position for a period of 15 minutes until the edema had subsided sufficiently to permit unembarrassed respiration. Intubation is not recommended in these cases because the opening through the tube

would be covered by the edematous aryepiglottic folds. In case of doubt regarding the diagnosis, direct laryngoscopy should always be performed. However, in some patients, if the tongue is firmly depressed, the epiglottis will come into view, so that one may determine whether there is a pale watery edema or whether the epiglottis is fiery red.

One of the best examples I have seen of acute supraglottic allergic edema was in a 6-year-old boy who had been given serum ten days previously. Epinephrine given subcutaneously quickly reduced the edema and dyspnea, so tracheotomy was not necessary.

Laryngeal Diphtheria

Laryngeal diphtheria sometimes occurs when there is no membrane visible on the pharynx or tonsils, so that accurate diagnosis of this condition must depend on direct laryngoscopy confirmed by smear and culture. However, certain points in the history and physical examination should lead the examiner to suspect its presence. Usually diphtheritic laryngitis is slower in development, with a lapse of two or three days from the onset of hoarseness until dyspnea is sufficiently marked to require tracheotomy. Usually the fever is not high and may be no more than 100° or 101°. The cry is hoarse because normal vibration of the cords is hampered by presence of the membrane. By contrast, in a patient having supraglottic edematous laryngitis or angioneurotic edema the cry is clear because there is no involvement of the true vocal cords. Laryngeal diphtheria sometimes produces a croupy cough because the latter is due to swelling of the conus elasticus. A croupy cough is produced most frequently by acute laryngotracheobronchitis or by "spasmodic croup," which in my opinion is due usually to subglottic allergic edema.

In all cases in which there is the faintest suspicion of diphtheria, smears and cultures should be made from exudate in the larynx. The specimen for culture can be most conveniently obtained by using an aspirating collector through a direct laryngoscope. If the laryngoscopic appearance suggests diphtheria, antitoxin should be given immediately. One should not wait for the laboratory report. In addition, penicillin (50,000 units to 100,000 units) should be given intramuscularly every three hours, day and night, because growth of the diphtheria bacillus is inhibited by penicillin.

Subglottic Allergic Edema

(Spasmodic croup) (Acute spasmodic laryngitis)

Characteristically, children with this disease are awakened at night by dyspnea, a croupy cough, and inspiratory stridor. They are usually quite well the preceding day, or may possibly have had a little rhinitis, but had no fever. By morning the symptoms have cleared up, but recur again the next night and possibly for several succeeding nights. For generations this clinical picture has been referred to as spasmodic croup, the inference being that the obstruction is due to adductor spasm of the vocal cords. I think this concept is erroneous for the following reasons: the sound of the croupy cough is identical with that produced by the subglottic swelling visualized by direct laryngoscopy in cases of acute laryngotracheobronchitis. In the few cases of so-called "spasmodic croup" that I have had an opportunity to observe in hospital practice, direct laryngoscopy showed pale watery edema of the subglottic tissues and the obstructive symptoms cleared up within 15 minutes after subcutaneous administration of a small dose of epinephrine. The rapid onset and later improvement in one to four hours of subglottic allergic edema is quite comparable to the transitory nature of hives in the skin. "Croup" has been referred to as a manifestation of allergy by many physicians who are experienced in dealing with allergic individuals. Some of these are Vaughan,⁴ Rowe,⁵ Cohen,⁶ Davison,⁷ Spain,⁸ Balyeat,⁹ Urbach,¹⁰ and Schwartz.¹¹

Pediatric textbooks^{12, 13, 14, 15} point out that some children who are subject to croup cannot sleep in cold or well-ventilated rooms without an attack developing. I think this well-known reaction is a manifestation of food allergy or of allergy to cold air, one type of physical allergy. The decided individual and family predisposition to develop "croup" also indicates allergy as an etiologic factor. Adenoids and a neurotic disposition are also mentioned as predisposing causes. Hypertrophy of lymphatic tissue and an unstable nervous system are characteristic of allergic individuals. I suggest the term subglottic allergic edema for this malady because it is descriptive of both the anatomic location and the etiology. It is distinguished from other forms of obstructive laryngitis by its sudden nocturnal

onset and by the complete or almost complete remission of symptoms during the daytime.

Four physicians to whom I suggested the use of epinephrine for treatment of nocturnal "spasmodic croup" reported that it was effective, and two of them said that use of elixir of benadryl saved them many night calls for youngsters who were subject to "croup." This observation also suggests that histamine release is a cause of at least some cases of nocturnal "croup." I am indebted to Drs. Holt, Smigelsky, Crater, and Schneider for these reports.

Acute Laryngotracheobronchitis

This disease most often begins as a primary subglottic laryngitis. These children have the dry, croupy cough and inspiratory stridor produced by subglottic swelling. In almost all cases the sound of the cry is clear, indicating that the edges of the vocal cords are normal and free from membrane. Temperature varies from 100° to 105°. Many of these patients have little fever, even when the obstruction is marked. The dyspnea becomes progressively worse over a period of one to seven days before it is severe enough to require admission to a hospital. Table I indicates that most of these patients had a primary subglottic laryngitis.¹⁶

TABLE I
MODE OF ONSET—52 CASES

Primary subglottic laryngitis	27
Previous head cold	21
Previous sore throat	1
Previous measles	1
Previous bronchitis	2

Many of them had previous head colds. Head colds cause nasal obstruction and mouth breathing so that the extremely dry indoor air in winter impinges directly upon the larynx without having previously been moistened by passage through the nose. Our cultures, and those of many other observers, indicate that any of the pathogenic gram-positive cocci can be the bacterial agent responsible for this disease.

Moreover, smears made from the intratracheal exudate showed many gram-positive cocci mixed with the pus cells, so I think it is not necessary to postulate a virus infection as the cause of this disease. In addition, most patients showed such prompt response to treatment with penicillin that it seemed evident that the infection was due to a penicillin-sensitive organism. It is well known

that virus infections do not respond to treatment with penicillin. The viral origin of acute subglottic laryngitis has been stressed by Rabe,^{2,3} and it is probable that a virus initiates the infection.

The pathologic changes observed by means of direct laryngoscopy and bronchoscopy are redness and swelling of the lateral walls of the trachea just below the vocal cords, so that the subglottic space is reduced to an anteroposterior slit 1 to 2 millimeters wide.¹⁷ Often the subglottic tissues are coated with a layer of dry, rough, gray, adherent exudate which extends downward a half inch below the level of the cords and increases the obstruction. Usually this exudate does not have the appearance of diphtheritic membrane. The swelling of the subglottic tissues is firm and indurated as demonstrated by the fact that it requires considerable pressure to introduce even a 3½ millimeter bronchoscope. This subglottic swelling is not due to simple watery edema, but is due to infiltration of the submucous tissues of the conus elasticus with inflammatory cells, as our postmortem examinations have shown.

These patients are placed immediately in a humidified oxygen tent and are given penicillin (50,000 to 100,000 units) by *intramuscular injection* every three hours, day and night. Our penicillin sensitivity cultures have shown that the organisms causing respiratory infections are becoming increasingly more resistant to the action of penicillin. Therefore, all seriously ill patients are given dihydrostreptomycin as well as penicillin. Most of the pathogenic gram-positive cocci are still sensitive to the action of dihydrostreptomycin in concentration of 10 micrograms per cc.

The high humidity¹⁸ in the oxygen tent which can be achieved by means of a mechanical humidifier helps greatly to maintain the fluidity of the tracheobronchial secretions and to soften the crusts adherent to the subglottic mucosa. Tracheotomy should be performed if respirations are seriously embarrassed, *or if the pulse rate continues to increase*. It is difficult to state in words just when a tracheotomy is necessary, but a pulse rate of over 140 is regarded as a danger sign. If dyspnea is not too marked at the time of admission, we place the child in a humidified tent, give the first dose of penicillin and dihydrostreptomycin, and record the rate of pulse and respiration every 15 minutes for a period of three hours. Increase or decrease in the objective signs of

dyspnea, and increase or decrease in the rate of pulse and respirations during that period of time will often settle the question. Delayed tracheotomy increases the probability of pneumonia due to lack of drainage of the tracheobronchial exudate.

During the past eight years I have treated 72 patients with this disease. There was one death in this series which included 18 patients who required tracheotomy. The low mortality rate in this series is attributed to (1) cool, moist air provided by a humidified oxygen tent, (2) adequate doses of penicillin, (3) avoidance of instrumental trauma to the mucosa of the trachea and bronchi, (4) postural drainage, (5) early tracheotomy, (6) transfusion when indicated, and (7) careful personal attention to each patient.

Foreign Bodies in the Larynx or Upper Trachea

In these cases the severity of the obstruction will depend on the size of the object and the traumatic or infectious edema which develops subsequently. Direct laryngoscopy and tracheoscopy should be done promptly to remove the object or to make certain that one is not dealing with a purely infectious type of obstruction.

Tracheal foreign body should always be considered when one sees a dyspneic child. A wheeze heard at the open mouth is usually present in foreign body cases.

Summary and Conclusions

1. Prompt differential diagnosis followed by modern methods of treatment will prevent death in nearly every case of acute obstructive laryngitis.
2. Acute supraglottic laryngitis may require tracheotomy within four hours of the onset of the first symptom.
3. Tracheotomy after introduction of a bronchoscope is the treatment of choice when obstruction is marked.

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ABSTRACT OF DISCUSSION

JOHN R. SIMPSON (Pittsburgh): We are very satisfied with the humidifying apparatus that we are using at Children's Hospital now. We haven't had to do any tracheotomies during the past year, but last year we did three and the patients all died; that is the worst record we have ever had. There have been years when we have done at least eighteen tracheotomies, and we have had as many as seven of these machines going at one time in the hospital. We find that either the type of infection is a much lower grade, or we are accomplishing something by the use of our humidifying machine.

I saw a patient not long ago who was in a humidifier but who wasn't doing very well. It is necessary to be on guard all the time to see that the nurses know how to operate the machine and keep it going, also keep the tent tucked in at the bottom so that there is not too much heat and not too much circulation of the room air.

ALEC R. SCHWARTZ (Pittsburgh): In providing that type of postural drainage for tracheal bronchitis, it would appear to me that it would increase the degree of dyspnea.

DR. DAVISON: No, it does not seem to increase it.

May I add that this type of postural drainage is used primarily after tracheotomy, and then there should be no dyspnea if the tracheotomy tube is functioning properly.

DR. SIMPSON: Galloway advocates helium. Have you ever used helium with oxygen, Dr. Davison?

DR. DAVISON: No, I have not. My feeling is that if these patients are ill enough to require helium, their condition is serious enough to require tracheotomy, and tracheotomy is done not only to furnish air but also drainage. If it is not done early enough, the secretions will dam back. They are quite viscid. There is a tendency to postpone operation, in which case there will be more cases of pneumonia due to damming back of secretion.

DR. SIMPSON: The cases I am referring to in which helium was used were those in which there was a tracheotomy. One was a polio case—two or three months before. The chest muscles were practically paralyzed, and a diaphragm was being used. We did a tracheotomy, and it did well for four or five days, but then there was a change for the worse. With the addition of helium to the oxygen, we ran a tube from the tanks over to the tracheotomy tube and saved the child. The superintendent said, "I don't know what you accomplished by saving the child."

HENRY M. HALL (Pittsburgh): The doctor mentioned pneumonia, and that interests me because when I first came to Pittsburgh I sent a little child with a papilloma of the throat to the Eye and Ear Hospital, and they sent him out with the same thing. Since pneumonia developed afterwards, it seemed to me as though the mechanical obstruction may predispose to pneumonia.

FLETCHER D. WOODWARD (Charlottesville, Va.): I should like to ask if there was any local chemotherapy in the tube, such as penicillin.

DR. DAVISON: I am lukewarm about topical application of antibiotics. I may be wrong, but I have the idea that penicillin aerosol used in this way is not very effective. I feel that a large parenteral dose will do more good because the organisms are in the submucosa and, to reach them, blood-borne drugs are essential. I am no doubt in the minority in expressing that opinion, but it is my personal conviction. I have more faith in large parenteral doses.



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EDITORIALS

FIRST USE OF GERM OR VIRUS WARFARE

The use of biological warfare was first initiated at Fort Pitt during Pittsburgh's frontier days in 1761-62, as stated recently by Perrin H. Long, M.D., of Baltimore, Md., in a paper which he read before the Allegheny County Medical Society marking the delivery of the periodic Nathaniel Bedford Lecture. Early in his lecture Dr. Long referred to Dr. Nathaniel Bedford as a distinguished physician and military surgeon arriving at Fort Pitt about 1765. (Dr. Bedford's remains lie buried in the 163-year-old burial ground of Trinity Episcopal Church on Sixth Avenue in downtown Pittsburgh.)

Dr. Long is professor of preventive medicine at Johns Hopkins University School of Medicine, and his lecture, printed in this issue of the JOURNAL, is outstanding in the dynamic field of antibiotics. All JOURNAL readers should seek out his latest advice on "the use of antibiotics in the prevention and treatment of infections."

For those who will not follow throughout the scientific bent of Dr. Long's address, we quote briefly, as appended, from its one thousand word introduction of historic content, in which the first use in warfare of a virus or germ-borne disease is dramatically described, only to be definitely

outlawed (we hope) many years later by international agreement.

I wonder how many of my auditors realize that the first (and probably most successful) use of biological warfare was initiated a few hundred yards from where we are gathered tonight. In 1761 or 1762, the confederation of Indian tribes under the leadership of the great Indian organizer and strategist, Pontiac, were again being incited by the French to action against the settlements and garrisons of the Royal Americans west of the Alleghenies. Lord Jeffrey Amherst ("a soldier of the King"), the chief of the Royal American Forces, plagued with the difficulties which confronted him in the maintenance of so far flung a frontier and with but a handful of troops, in a postscript to a letter written by him to Bouquet at Fort Pitt suggested that an epidemic of smallpox be started among the hostile Mingoe and Delaware Indians. In his reply to Lord Jeffrey ("He fought with all the Indians that came within his sight"), and again in a postscript, Bouquet replied, "I will try to inoculate—with some blankets that may fall into their hands and take care not to get the disease myself." As smallpox was present in Fort Pitt, this was not difficult to do. In his comment on Bouquet's plan, Lord Jeffrey wrote, "You will do well to try to inoculate the Indians by means of blankets as well as to try every other method that can serve to extirpate this execrable race."

That this plan was well conceived and tactfully sound is indicated from the following excerpt from the diary of a Captain Ecuyer of the Royal American Forces at Fort Pitt dated June 24, 1762: "Out of our regards for them (the Indians), we gave them two blankets and a

handkerchief out of the smallpox hospital. I hope it will have the desired effect." The results probably exceeded Lord Jeffrey's ("and he looked around for more when he was through") best expectations, because within a short time smallpox was sweeping through the Ohio tribes in an epidemic which persisted for more than a year. It appears that one of the major factors which led the French to terminate this war and subsequently cede Canada to Great Britain was the failure of their western Indian allies to take the offensive in 1762.

I plan initially to discuss the prevalence of disease and its consequences in Dr. Bedford's era as contrasted with that which we, as physicians, are facing in the present era. . . . *see page 209.*

MODERN TREATMENT OF RHEUMATOID ARTHRITIS

During the past quarter-century improvements in treatment of rheumatoid arthritis with gold have culminated in therapeutic regimens equaling in efficacy the therapy of any similar chronic disease. Approximately one-half of arthritics on gold therapy now obtain remissions of from one to seven years and more. When potent hormone products became available, each in its turn has been tried in arthritis. During the past ten to fifteen years favorable reactions have been given by estrogen in menopausal and other forms of arthritis. Testosterone, progesterone, and desoxycorticosterone were found to be of value when used alone or concurrently with gold.

In the past two years undue lay publicity has been given to the ephemeral, dramatic improvement in rheumatoid arthritis, lupus erythematosus, and other collagen diseases under therapy with cortisone and ACTH. It soon became evident that neither of these two remedies is ideal. Although the percentage of response is high and improvement is rapid, recurrence upon withdrawal of therapy is prompt and frequently the condition is worse than before therapy. Severe complications, such as a pseudo-Cushing's syndrome, permanent diabetes, and psychoses sometimes occur. Moreover, the supplies of cortisone and ACTH are too limited for wide use.

Search, therefore, was made for a more readily available steroid giving the same initial but more lasting benefit without the undesirable side effects. Of the several steroids investigated, the two most promising are pregnenolone and acetoxypregnenolone. Pregnenolone has been used in nearly 300 rheumatoid arthritics, 75 per cent of

whom have shown definite subjective and objective improvement. This study is too recent for valid comparison of the remissions so obtained with those from gold therapy as mentioned above, and there has been insufficient opportunity for as careful a regulation of dosage regimen as that of gold; yet, even now, the benefits from pregnenolone therapy approximate those from cortisone and ACTH without any of the undesirable side effects. Pregnenolone appears to be totally non-toxic and apparently may be administered over indefinite periods without the dangers incident to cortisone and ACTH. Pregnenolone and cortisone have several hormone properties, but they are used in dosages hundreds of times those of conventional steroid hormones and, therefore, they probably act in arthritis not as hormones but as pharmacologic agents directly upon the diseased structures.

Recently we have found that the addition of a wetting substance, or spreading agent, the enzyme extracted from bull testes, hyaluronidase, when added to intramuscular steroid preparations, accelerates absorption, hastens clinical response, lessens the pain of injection, and diminishes the incidence of sterile abscess.

Rheumatologists are now seeking the ideal combination of steroid and gold therapy. It may eventuate that initial therapy with cortisone followed by ACTH and then sustained maintenance with pregnenolone, or acetoxypregnenolone, and finally, long-term therapy with gold alone or in steroid combination, or some such regimen, may prove to be optimal. Many steroid combinations are being tried similarly.

The Council on Pharmacy and Chemistry of the American Medical Association recently warned against the widespread use of cortisone and ACTH in the routine practice of medicine and recommended that their use be restricted to studies of the nature and mechanism of a disorder such as rheumatoid arthritis.

The low toxicities of pregnenolone and acetoxypregnenolone qualify them for more widespread use, but until more is known concerning the optimum choice, succession and dosage regimens of these steroids, the statement made frequently during the last quarter-century is still valid, namely, that gold remains the most efficacious single remedy in rheumatoid arthritis.

ABRAHAM COHEN, M.D., Philadelphia, Pa.
THOMAS J. MCBRIDE, M.D., Chester, Pa.

PHYSICIAN, AID YOUR PATIENT AS YOU WOULD BE AIDED

The editor believes that there is much of general community interest in the article appearing on page 219 entitled "The Psychiatric Unit in the General Hospital."

The concept of this article is well within the minutia of the same problem of two score counties in the Keystone State. We commend its reading by all who sense the need for wider understanding of the part that private practice and non-government hospitals should play in the prophylaxis and treatment of mental illness.

MEDICAL SCIENCE IN THE MARKET PLACE

A trend for exploiting medical topics in the public press is gaining more and more momentum. Many so-called science writers are no longer satisfied with writing news about scientific discoveries. They seek to ferret out every bit of new work which is just under way and blare it to the world as a tremendous new discovery. These writers, as is customary in the business-journalistic world, vie with one another in searching out the researchers in order to establish a journalistic "scoop." This sort of thing results in untold danger to the population. The scientific worker, who is accustomed to check and recheck his results, to make comparisons, to have his experiments repeated by other workers in the same field, is literally rushed off his feet and not given a chance to reflect. It must be admitted that some scientific workers are not averse to the publicity they get, but the vast majority of them are more the victims than the culprits.

Even more serious is the trend to usurpation of the scientific prerogative in recent years by some journals. The well-known little pocket journal with its scientific oracle, who knows all the answers, is by now a by-word. Its most recent exploit is truly "stupendous." We refer to the "marvelous" antihistamine craze in the treatment of colds, which is the "discovery of the age." This time pharmaceutical concerns, out for as much of the "kill" as they can pocket, try to outdo one another. "Our product kills a cold not in days but in hours" bellows one announcer on

the radio; and the very next announcer for another concern counters with "greatest medical discovery; sulfa in 1935; penicillin in 1942, and 'Aunt Histin' in 1949." To the lay mind, apparently even the sameness of the interval that has elapsed is a good talking point for his product. And still another simply praises his product as living up to all the rigid tests as published in. . . . Oh, no, dear reader. Do not think for a moment that it was published in a leading medical journal. Perish the thought. . . . as published in the "Ravenous Digest." No longer do we need a diagnosis. Of course, you have a cold. Just take our tablet and pronto.

This entire trend is extremely dangerous and a halt should be called to this arrogant usurpation of a function for which such persons are eminently unfit. This is imperative in the interest of community health and welfare.

MAX H. WEINBERG, M.D.

SQUARELY IN THE AGGRESSOR'S PATH

From an editorial in the February 1 issue of the *New York State Journal of Medicine* we are glad to quote salient paragraphs which boldly indict those who through a "cold war seek the dissolution of the medical profession":

" . . . The aggressor in this modern war is subtle. The aggressor in this cold war uses poisons, not to kill but to blunt the intellect, to warp the judgment, to distort the facts, to undermine resistance, to substitute false values for true, to bribe with subsidy, to press upon the palsied necks of bemused people the heavy yoke of arrogant authority, oppressive controls, exorbitant taxes, to set one man against another in suspicion and hate. His poisons produce a lassitude, a desire not to think independently but to follow blindly, a contentment to be dependent, to permit others to control and regulate, to be spendthrift and heedless. His poisons are propaganda and distortions of truth, false promises and lies.

"The profession of medicine stands squarely in the aggressor's path of conquest; it benefits the people directly; it frees them from disease; it binds up their wounds; it comforts them; it stands between them and the spectre of death

from the cradle to the grave. No aggressor can view such potential power unmoved. It incites him to envy, covetousness, malice, hatred, and all manner of uncharitableness. Therefore, he must destroy it, accomplish its dissolution, and annex it piecemeal. It is the technique of Fabius.

"It is fortunate that the general staff of the American Medical Association has recognized the attack for what it is. A year ago the trustees, after deliberation, assessed the membership \$25 apiece to commence a campaign of public education. No more than the then hue and cry, the cacophony of discordant protests, the stridulous yells of the dupes of the aggressor were necessary to prove that the forces of discord, the sappers and fifth columnists were at their work. The barrage of criticism of the profession in some of the public press that followed and has continued to rise in volume, dedicated to breaking up the unity of the doctors, discrediting them and their institutions, is again ample reason for the action of the House of Delegates in December, 1949, unanimously to vote annual dues of \$25 a member.

"No man can serve two masters. He that is not for us is against us. This is war. The *Journal* is proud to urge every doctor in the Empire State to pay his dues promptly. War is costly. It is not of our seeking. To prosecute it successfully money must be forthcoming. Now."

CARCINOMA OF THE GALLBLADDER A DIAGNOSTIC PROBLEM

This year 6000 persons will die of cancer of the gallbladder.

The problem of carcinoma of the gallbladder resides in the following questions:

1. Is this cancer of sufficient frequency to challenge the interest of the clinician and surgeon?
2. What is the relationship between cholelithiasis and gallbladder carcinoma? This involves a consideration of not only symptomatic cholecystitis but also the moot problem of "silent stone."
3. Are there any diagnostic criteria that would indicate early malignancy of the gallbladder, that is, the cancer amenable to adequate resection?

Six thousand five hundred persons will die this year of primary cancer of the gallbladder. This surprisingly high figure should claim the attention of the profession. Yet, in the past, in medical school teaching and in graduate symposia on gallbladder disease, this aspect of biliary tract pathology has not received due consideration. We have been struck by the frequency with which carcinoma of the gallbladder has unexpectedly confronted us at the operating table. A study of the pathology, as noted in our series of 500 consecutive cases⁵ of gallbladder disease, reveals an incidence of 2.8 per cent of primary carcinoma of the gallbladder. In other words, *one of every 36 of these operative cases showed definite evidence of cancer of the gallbladder.*

Boyd¹ considers primary gallbladder malignancy a not uncommon condition. He classifies the vast majority of cases as adenocarcinoma, but recognizes the occasional metaplasia of columnar epithelium to squamous epithelium. Three of our 14 cases showed evidence of such epidermoid change. He reminds us also that invasion of the liver and neighboring lymphatics occurs very early in the disease—so rapidly, in fact, that by the time evidence of malignancy (i.e., jaundice, weight loss, etc.) has manifested itself, operative palliation is doomed to failure.

It has been frequently observed that the presence of gallstones must be related to the origin of the cancer. The derivatives of cholic acid are among the most powerful of carcinogens.³ Of those who had primary carcinoma of the organ, cholelithiasis was present 75 per cent of the time. However, in 3 of 14 cases, the gallbladder was not explored and the presence of calculus not definitely established. To be sure, it is recognized that stones are not the entire story regarding the etiology of cancer. Malignancy may arise from pre-existing benign tumors and so-called "cell rests." On the other hand, in cases of proven cholelithiasis, what percentage of carcinoma may we expect to find? In our study, in 350 cases of gallstones there were ten instances of cancer, an incidence of 2.9 per cent. The average report in the literature varies from 2 to 5 per cent. However, the vast majority of such statistics deal with cholelithiasis associated with symptoms, since this is the type of patient most usually coming to operation. Is this, then, a significant percentage to justify cholecystectomy for all calculous gallbladders—symptomatic or silent—as a prophylactic measure against cancer?

Approximately one-fifth of the adult population coming to autopsy have stones. In a series of 1000 consecutive routine postmortem examinations performed in Vienna, Crump² found biliary calculi in 32.5 per cent of all cases. Graham³ and his co-workers found that 20 to 25 per cent of all adults have cholelithiasis. Criticism has been leveled against these statistics on the ground that they are based on autopsy findings and do not represent a true cross-section of the adult population. Truesdell⁴ found an incidental cholelithiasis in 10 per cent of 500 patients coming to operation for procedures other than cholecystectomy. Further questioning of these 50 patients, and later follow-up, revealed the fact that only six could be considered as having "silent stones."

In our series of 14 cases, only one malignancy associated with stones was asymptomatic. Here, palpation of the gallbladder and subsequent cholecystectomy were incidental to the repair of an incisional hernia. *This was the only case that was resectable for cure.* That is to say, the lesion was entirely in the gallbladder with no evidence of spread either macroscopically or microscopically. This might lead to the concept of cholecystectomy for all cases with stones, with the hope of discovering and resecting the clinically unrecognized carcinoma. Perhaps only then could we reduce the total mortality from gallbladder carcinoma. Considering the other complications associated with calculi, cholecystectomy for these patients may often represent a valid conclusion. At least these people should be followed, checked periodically, and not dismissed with the admonition, "the stone doesn't bother you, don't bother it."

All agree that pain, dyspepsia, and later, weight loss, jaundice, and a palpable mass are common findings of gallbladder malignancy. Weight loss was marked in 7 of our 14 cases. In two there was none, and in 5 cases alteration of weight was not mentioned. Jaundice, when present, was more severe, increased more steadily and relentlessly than in uncomplicated cholelithiasis. Unfortunately, the significant findings mentioned above appeared only when a case was incurable. Just as with carcinoma of the stomach, we must establish other criteria for earlier diagnosis.

Fifty per cent of our cancer patients were between the ages of 60 and 70 years. Of the 500 cases reviewed, 70 patients were in this age group. In other words, seven instances of malignancy

were found in this age group consisting of 70 cases of gallbladder disease. *Ten per cent of all gallbladder operatives in the seventh decade showed evidence of cancer.*

To summarize, we should like to emphasize the following points:

1. Carcinoma of the gallbladder is not a rare disease. Cholelithiasis and cholecystitis are common antecedents and 1 to 10 per cent of this category may have biliary cancer depending upon the decade of life.

2. Approximately 2 to 5 per cent of all cholelithiasis is associated with malignancy. In our series, 75 per cent of all gallbladder malignancy was preceded by stones.

3. The presence of a "silent stone" may in itself demand surgery. However, we have not been able to find statistics on the relationship of biliary cancer to asymptomatic cholelithiasis. At present, the practicality of routine surgery in the absence of symptoms is questioned by many.

4. When a preoperative diagnosis of biliary carcinoma is possible by present-day studies, it is beyond surgical resection or palliation. This is based on the popular conception of the disease and is usually a "too late" clinical picture—jaundice, mass, hepatomegaly, marked weight loss, and marked anemia. On the other hand, we should keep in mind the syndrome *suggestive* of cancer of the gallbladder, one that may be early enough for cure or palliation—cholelithiasis, sixth decade or older, first appearance of symptoms (e.g., mild dyspepsia), aggravation or exacerbation of symptoms, and change in clinical picture (weight loss, anemia, icterus). Careful interrogation, examinations, and follow-up study may reveal that many "silent stones" are not innocuous.

In conclusion, cancer of the gallbladder presents an unsolved clinical picture. Too often the family physician or internist is prone to treat older people with symptomatic calculous cholecystitis by a conservative régime including duodenal drainage. These patients, abhorring the thought of surgery, gratefully acquiesce and cheerfully suffer the disease as well as the treatment. Often the surgeon is apt to be persuaded that the medical status contraindicates surgery. Usually this over-all attitude is the culmination of a deep-seated prejudice against surgery in the older patient as well as a deep faith in the possibly innocuous "silent stone." However, the attitude of geriatric medicine towards surgery is

a more confident one today. Certainly complications of cholelithiasis, i.e., recurrent cholecystitis, hydrops, perforation, common duct obstruction, pancreatitis, etc., are familiar to all. These are reasons enough to look with suspicion on cases of so-called "silent stone." Finally, on the basis of malignancy alone, our review would indicate that more serious and thoughtful consideration should be given to exploring these cases. A reasonably measured suspicion of cancer in all cases of cholelithiasis may favorably alter the prognosis of some of the patients who are destined to die of carcinoma of the gallbladder.—ALEXANDER W. ULIN, M.D., Philadelphia, Pa., and IRVING L. LICHTENSTEIN, M.D., Los Angeles, Calif.

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REVIEW OF CASES OF INTEREST TO PHYSICIANS DECIDED IN PENNSYLVANIA APPELLATE COURTS, TERM 1948-1949

(EDITOR'S NOTE: Mr. William A. Challener, Jr., who with his distinguished father has served the Allegheny County Medical Society as legal counsel—the latter through three decades, has prepared for the JOURNAL the appended brief review which definitely should be of interest to doctors of medicine. The first installment appeared in the February issue.)

Revocation of License

A license to practice medicine obtained through fraud, misrepresentation, or deception may be revoked at any time. The mere passage of time does not invoke the doctrine of laches so as to prohibit the Board of Medical Education and Licensure from revoking it, but since length of time obscures all human evidence and as it removes from the parties all the immediate means to verify the nature of the original transactions, it operates by way of presumption, in favor of innocence, and against imputation of fraud.

In *Pennsylvania State Board of Medical Education and Licensure v. Schireson* (360 Pa. 129) the Board revoked a license, issued almost thirty-eight years before, to practice medicine and sur-

gery in this Commonwealth on the ground that it had been obtained through fraud.

One of the questions considered was whether there was substantial evidence to support the finding that appellant committed fraud in submitting a sworn application for licensure, which stated that he had studied medicine for four years and that he attended the University of Maryland during the academic year 1902-03.

While the printed catalogue of the School of Medicine of the University of Maryland did not mention the licensee as a member of the class of which he contended he was a member, the only other living witness with knowledge of the facts in dispute stated that he and appellant registered together on the same day and that the appellant had attended the University of Maryland Medical School during the year in question.

On appeal by the licensee from an order of the Court of Common Pleas of Dauphin County which affirmed the action of the State Board of Medical Education and Licensure in revoking his license, it was held that the weak and inconclusive evidence adduced by the Board did not rebut the presumption of innocence and that the alleged fraud had not been proved, and it was directed that the license be reinstated.

Criminal Law

In an indictment charging the defendant with fornication and bastardy, a verdict of guilty as to bastardy was reversed and set aside where the medical witness for the prosecution set the period of gestation as from 260 to 340 days. Since the alleged intercourse had occurred 252 days before the birth, the Commonwealth's own medical testimony absolved the defendant as to the charge of bastardy (*Commonwealth v. Jodlowsky*, 163 Pa. Superior Ct. 284).

In an indictment charging the defendant, a practicing physician, with having carnal knowledge of a young married woman patient in his office, while she ostensibly was being given medical treatment, a verdict of guilty as to rape was affirmed by the Superior Court although that court stated that parts of the testimony of the prosecutrix appeared rather farfetched and pointed out that such a charge is difficult to defend (*Commonwealth v. Morgan*, 162 Pa. Superior Ct. 105; reversed 358 Pa. 607).

On appeal to the Supreme Court the conviction was set aside and the case remanded for a new trial because the trial judge permitted the

prosecutrix, who was sobbing, to assume, at the direction of the district attorney and over the objection of the defendant, a position on a table in the court room such as that in which she was when the alleged attack occurred. Mr. Chief Justice Maxey held that such pelvic posturing as was permitted in the trial of this case was prejudicial and constituted reversible error.

Agency—Malpractice

In *McConnell v. Williams* (361 Pa. 355) liability of the defendant physician was made to depend on the jury's determination as to whether a hospital intern was his agent in applying silver nitrate to the eyes of the newborn child of the patient.

The facts—assuming plaintiff's testimony to be true—are these: Mrs. McConnell engaged the defendant to attend her during her pregnancy and to deliver her of an expected child. Finding that a cesarean operation would be necessary, defendant suggested that it be performed at a hospital where he was one of the chiefs of the obstetrical staff, and accordingly she entered there on Dec. 2, 1943.

On December 3 defendant requested one of the interns at the hospital to attend on the following day "to be his assistant and to take care of the baby at the time of the operation," but, being told that that intern would not be on duty, he asked that a certain other intern whose name he mentioned should be informed that "he was to be his assistant and take care of the baby at the time of the delivery." The operation took place on December 4; in the operating room, in addition to defendant and the patient, there were present a nurse attached to the hospital, another nurse privately engaged by Mrs. McConnell, and the intern whom defendant had designated. The operation was a difficult one; the patient suffered profuse hemorrhages which required the surgeon's complete attention. When the child was delivered, he turned it over to the intern for the purpose of tying the cord and applying a solution of silver nitrate to the infant's eyes. According to the testimony of Mrs. McConnell's nurse, the intern in this case filled a syringe and squirted a 2.1 solution once into the child's left eye and twice into its right eye, putting into the latter "a great many drops"; moreover, he failed to irrigate the eyes during at least the period of five or ten minutes while this nurse remained in the operating room. The result was that the

child lost the sight in her right eye completely, which was so badly burned that it later had to be excised, necessitating a plastic operation and the substitution of a glass eye which she will be obliged to wear throughout her life; the left eye was also severely and permanently scarred.

The Supreme Court held that this testimony made out a prima facie case of negligence against the intern and, if the jury found that the intern was the agent of the surgeon, then a verdict could be rendered against the surgeon under the doctrine of respondeat superior.

The effect of this far-reaching decision is to make an operating surgeon responsible not for his personal negligence but for the negligence of a person over whom he has no effective control.

It is submitted that this decision imposes both an impracticable and an impossible burden. When the patient entered the hospital, she knew or should have known that the approaching birth would require the assistance and services of an anesthetist, of nurses and of interns, in addition to the services of her obstetrician. Even though the anesthetist, the nurses, and the interns may be under the surgeon's general control while the operation or delivery is in progress, they are not working for the surgeon. He has no voice in their selection. They are employed by, are working for, and are supplied by the hospital. The operation could not have been performed without their aid and assistance, and an intern would have been delegated to act as the surgeon's assistant if he had failed to express his personal choice of the interns available. The operation was a difficult one and required the surgeon's complete attention. Even after the delivery, when the child was turned over to the intern for the purpose of tying the cord and applying the silver nitrate, the surgeon's skill, attention, and concentration were necessarily devoted to the mother.

Surely the surgeon was entitled to rely on the competency of the trained personnel supplied by the hospital and upon the competency of an intern who had just completed the rigorous course of studies required for graduation from our medical schools. While admittedly a man may be a servant even while acting in a professional capacity, yet normally under such circumstances this relationship does not arise, particularly when their duty is to exercise professional skill and judgment in the performance of the act. Here the instillation of the silver nitrate was left to the professional skill and judgment of an intern

where competence is not questioned and no vicarious liability should be visited upon the surgeon.

WILLIAM A. CHALLENGER, JR.,
Challener & Challener,
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Medical Society.

KEYSTONES OF PUBLIC HEALTH FOR PENNSYLVANIA

Accident Prevention

EDITOR'S NOTE: This is the fourth of a series of guest editorials planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.

In "Keystones of Public Health for Pennsylvania," a survey by the American Public Health Association, pages 283 and 284 are devoted to the problem of accident prevention. The following are the salient comments on the problem:

1. Of the principal causes of death in 1946, accidents ranked fifth, being responsible for 6237 fatalities. No total figures are available for the number of persons disabled as a result of accidental causes.

2. The Department of Labor and Industry has concentrated on the reduction of occupational accidents, and the Bureau of Highway Safety in the Department of Revenue has engaged in the reduction of motor vehicle accidents not occurring on industrial property.

3. In the four-year period, 1942-1946, motor vehicle accidents caused 7567 deaths, which is 23.7 per cent of all deaths due to accidental causes. Pennsylvania is among the eleven states having death rates of less than 21 per 100,000 population from this cause. Comparisons with other northeastern states are contained in the article and may be mentioned as favorable.

The Bureau of Highway Safety has studied and analyzed accidents due to motor vehicles in Pennsylvania considering cause, time of accident, highway route number, county, etc., and further has developed a planning, engineering, and educational program to combat these accidents.

4. There were 1136 deaths resulting from occupational accidents in 1946, or a death rate of

32.5 per 100,000 workers. In the same year, a total of 116,220 disabling injuries were reported. Of these, 4498 received compensation for some degree of permanent impairment. These accidents cost industry about \$16,000,000 for compensation alone, in addition to the amount spent for medical care, etc.

The Bureau of Inspection in the Department of Labor and Industry has been for many years active in the reduction of occupational disease accidents. Accident data is collected and analyzed, safety engineers are provided, and inspectors are distributed throughout the state to advise employers and employees in safety measures. The end result has been a downward trend, during the past thirty years, in fatal and non-fatal accidents.

The report calls attention to the fact that, at present, no working relationship exists between the Department of Labor and Industry and the Department of Health.

"Keystones" states that, according to the National Safety Council, the greatest number of fatal and non-fatal accidents in 1947 occurred in the home. No figures are available for Pennsylvania, but undoubtedly the experience here parallels the nation as a whole.

This reviewer quotes from the editorial page of the *Scranton Times*, under the heading, "Bedrooms Top the List." (Figures are derived from a chart prepared by the National Safety Council.)

"One-fourth of all fatal mishaps in homes take place in the part set aside for rest—the bedroom. Kitchens contribute 10.3 per cent to the casualty roll, while 11.6 per cent is charged to yards and 7.4 per cent to inside stairways . . . only 3.5 per cent of all home fatalities are chargeable to bathroom mishaps, with the dining room percentage being 3.4 and the living room 5.9."

The editorial continues by quoting certain "musts" from the *Erie Railroad Magazine* in attempting to guard against home accidents.

That the public is tremendously interested in this problem of accident prevention is indicated by a second editorial in the same paper on the same day under the heading, "Keep Children Safe."

This article discusses the "heavy responsibility in keeping school children safe from harm on the highway," and quotes passages from a letter written by the president of the local traction

company to bus and street car operators, suggesting careful operation of "buses, street cars, automobiles and trucks" in order to give parents "a finer feeling of security for their children."

In conclusion, it may be said that statistics show a higher rate of mortality in children from accidents than from communicable disease.

The "Keystones" Health Survey makes these valuable recommendations:

1. That the Pennsylvania Department of Health establish a division of accident prevention with an adequate, well-trained staff.

2. That the division conduct an intensive accident prevention program, concentrating on the

prevention of home accidents in particular and on all other types of accidents in cooperation with other organizations already engaged in this activity.

3. That the division guide and stimulate local health personnel in the prevention of accidents.

In view of the increased incidence of accidents, as contrasted with the great progress in the control and treatment of infectious disease, it would seem that the above recommendations, in whole or, at least, in part, might well be adopted by the Pennsylvania Department of Health.

VINCENT T. CURTIN, M.D.

SCHOLARSHIPS OFFERED FOR TUBERCULOSIS POSTGRADUATE COURSE

Scholarships for the annual postgraduate course of the Trudeau School of Tuberculosis at Saranac Lake, N. Y., are again being offered by the Pennsylvania Tuberculosis and Health Society.

The four weeks' course this year will begin on May 1 rather than in September, as has been the practice in past years.

This is the thirteenth year in which these scholarships have been made available to physicians engaged in general practice in rural and small town communities in Pennsylvania. Up to this time 27 physicians located in as many different communities in the State have been awarded scholarships and taken the course.

The scholarships are in amounts of \$375, of which \$100 is for the tuition fee, to be paid directly to the Trudeau School by the Pennsylvania Tuberculosis and Health Society.

The course has become so highly regarded and popular among physicians wishing to do postgraduate study in tuberculosis that it is impossible for the school to accept all applicants. However, four places are being held for Pennsylvania physicians who may be awarded scholarships by the Pennsylvania Society.

The program aims to present the essentials of history, etiology, epidemiology, pathology, diagnosis, prognosis, and treatment. Emphasis is placed on bedside teaching and the clinical study and treatment of patients, combined with x-ray and pathologic conferences. Students participate actively in the study and presentation of cases. The class will be divided into groups of four for bedside conferences and observation of surgical procedures. The teaching staff is composed of outstanding specialists in all aspects of tuberculosis.

Scholarship awards will be determined by a committee of competent tuberculosis specialists practicing in Pennsylvania.

Because of the comparatively short period until the opening of the course, interested physicians should write promptly to the Pennsylvania Tuberculosis and Health Society, 311 S. Juniper Street, Philadelphia 7, for application forms and, if desired, further information. While four places are being held open by the Trudeau School for Pennsylvania physicians, this cannot be done indefinitely in fairness to other applicants.

PHILADELPHIA COUNTY TO HOLD FOURTEENTH POSTGRADUATE INSTITUTE

The Philadelphia County Medical Society will hold its fourteenth annual Postgraduate Institute at the Bellevue-Stratford Hotel in Philadelphia, April 25-28, 1950. Among the subjects to be covered will be pediatrics, virus diseases of the skin, antibiotics and chemotherapy, management of inoperable malignancy, rehabilitation, carcinoma of the prostate, problems of adolescence, epilepsy, gastro-intestinal hemorrhages, obstetric and gynecologic problems, geriatrics, fractures, and arthritis. There will also be two special evening sessions at the hotel, one consisting of a clinicopathologic conference and the other dealing with problems of alcoholism.

Arrangements are being made to record the material presented in the question and answer period following each lecture, and a summary of this material will be made available to each paid registrant. The registration fee is \$10, payable in advance or at the time of registration. The usual variety of high-grade technical exhibits will be part of the meeting. Preliminary programs have already been mailed to all physicians in Pennsylvania, New Jersey, Delaware, Maryland, and the District of Columbia, but additional copies may be secured by writing to Gilson Colby Engel, M.D., director, 301 South Twenty-first St., Philadelphia 3, Pa.

"If the Shoe Fits..."

The value of an exhibit booth is twofold: (1) to distribute literature and impress one or two clear facts on the passers-by through means of a display; (2) to question visitors to the booth and thereby obtain a cross-section of public opinion. This is not an accurate cross-section and does not necessarily express the opinion of any group of people, but it does provide worth-while comment.

Members of the public relations staff who manned the Medical Society booth at the State Farm Show, January 9 to 13, 1950, talked with a great many people. Governor Duff said not long ago that the farmers are the best informed group of people in the country today. The comments we received seemed to bear this out. While it may not be significant, we found that the farmers to whom we talked were generally opposed to socialized medicine, although in many cases they were not completely satisfied with present conditions.

These, then, were some of the remarks we noted. The comments on this page did not come from farmers. Others appear on the opposite page. Mark them well and "if the shoe fits. . . ."

"As a dentist and once connected with the Veterans Administration, I know what Federal medicine would mean. One VA office in Upper Darby closed and moved into Philadelphia and the records were lost for six months—including my reports and bills. No one but the government could run a business like that. Harry Truman is only interested as a politician, not as a friend of the people. There is no such thing as something for nothing—which is what a lot of people think they are going to get through Federal medicine."

* * *

"What's the idea of this propaganda? Socialized medicine has been successful in England. People do have the choice of their own doctors. The government can give all the people cheaper medical care. The doctors are against socialized medicine. Naturally—doctors are taking advantage of the entire country. They don't tell you how they abuse their profession. It's no longer a public service.

"You say that socialized medicine will destroy the initiative of young people planning to enter the medical profession. Then why is it that there are more than enough applicants for every government job open today?"

MEDICAL PROGRESS
The Medical Society of the State of Pennsylvania

IN YOUR HANDS

1925
5068 Pennsylvania children died from
measles 33
scarlet fever 17
whooping cough 10
diphtheria 24

PENNSYLVANIA'S MOST VALUABLE PRODUCT
Our Children
PROTECTED BY THE MIRACLES OF MEDICAL SCIENCE

Center panel of the State Society's display at the 1950 Farm Show making an appeal for inoculation of every child of preschool age

Question: Are you interested in socialized medicine and/or how do you feel about it?

Answers:

"I am whole-heartedly for it. My wife was born in Germany. The people there want and approve of socialized medicine. It has been successful there and should be successful here. Nearly everyone feels that it is a wonderful thing, especially all the poor people who cannot afford high-priced, proper medicine. This one-sided propaganda makes me mad!"

"It'll never pass Congress."

"Our government's getting silly—yes—silly. With the help of God and my own family doctor, I'll get along. I'll always manage somehow without the government."

"I'm against socialization of any kind. Americans should wake up before it's too late. Something for nothing just doesn't exist. And this administration is "shooting the works" for votes. I hope the people soon begin to think for themselves. The more I study the political background of socialized medicine, the more I'm against it."

"This country needs socialism—every kind."
—COLLEGE STUDENT.

"I'm a laboring man myself—CIO—and I know how they (Communists) are infiltrating into politics and doing our thinking for us. If liberty-loving people don't start getting active against these leftist agitators (and the CIO has plenty of them), there won't be any individualism in the United States any more than there is in Russia."

"I'm opposed to socialized medicine. I'm in the insurance business and I believe in free enterprise, but I'm afraid that when the 'say-so' comes in Congress, there won't be enough opposed. Keep up the good work."

"I was an Army man. I want no part of regimented medicine. The story of the country doctor is an American legend that should never be changed. I know, for my father has been a country doctor for over sixty years."

"I pity the people who can't afford doctors' high prices. I'll pity them more if this compulsory business goes through. They'll be run

through like cattle. And what kind of doctors will we have? No young fellow will want to be a slave to government red tape. Result? Fewer and poorer doctors."

"Don't know enough about it, but from the newspapers it seems to have failed abroad."

"I think it's a good thing, because more people will receive medical care, especially children in large families where wages are low."

"The American people will not accept government control of their most respected profession."

"I don't think we'll ever get socialized medicine, but I sure pity the country if we do. Most people won't think about it until they see the deductions on their pay checks and then it will be too late. One thing I know—most progressive business organizations are opposed to it."

"I'm from Duncannon High School. We students are very much interested in the socialized medicine controversy. We took a public opinion poll there and sent the results to *Scholastic Magazine*. Most of us are opposed to government-controlled medicine. That's the opening wedge of Communism. This voluntary idea you're talking about sounds like a much more sensible idea—more democratic. I'm against socialized medicine."

"I'm opposed to it because of what it will do to the doctor's attitude. The young man going into medicine will have no incentive. I've seen what the opportunity to get ahead has done for certain doctors. Take away that opportunity and you have a poor brand of medicine. Plus all this, the hypochondriacs will get the attention and people who are really ill won't go to the doctor because they won't want to wade through the mob."

"Why bother passing pamphlets out? The bill's going to pass, isn't it?"

"I'm a Republican and I'm against socialized medicine, but I'd like to say that doctors would get further with their side of the question if they'd stop being so independent and act like they care about the man in the street."

"I'm in favor of voluntary health insurance. I am not in favor of compulsory health insurance, but I think the doctors certainly need to clean their own house."—Prepared by the staff of the Committee on Public Relations, M.S.S.P.

THE STORY OF TEN LITTLE FREE WORKERS

THESE ARE THE WORKERS



Ten little free workers in this country fine and fair.
But if you cherish your freedom - worker have a care.
Ten little free workers - Reddy was doing fine
Until the socialists got him and then there were nine.



Nine free workers laughed at Reddy's fate
Along came federal medicine - then there were eight.



Eight free workers thought this country heaven
But the Government took over the railroads, then there were seven.



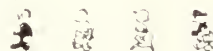
Seven free workers - 'till the miners got in a fix
Uncle said coal's essential and took over, leaving six.



Six free workers 'till the day did arrive
The steel mills were federalized - then there were five.



Five free workers - the farmers are free no more
The farms have been collectivized, leaving only four.



Four free workers 'till the Government did decree
All must have free legal advice, then there were three.



Three free workers, the number is getting few
With Government groceries selling food, then there were only two.



Two free workers, our story's almost done
With clerks at work in federal stores, that leaves only one.



One free worker - the reporter son-of-a-gun
Mustn't criticize Government - so now there are none.



Ten little workers - but they are no longer free
They work when and where ordered, and at a fixed rate, you see
It all could have been prevented if they'd only seen fit to agree
And work together instead of saying, "IT NEVER CAN HAPPEN TO ME".

Reddy Kilowatt is a copyrighted symbol of business-managed electric companies.

"The Story of Ten Little Free Workers" appeared originally as an advertisement for the Potomac Edison Company, Hagerstown, Md. Additional copies may be obtained by writing to the Committee on Public Relations, 230 State St., Harrisburg, Pa.

TEN YEARS OF COMMUNITY SERVICE

Medical Service Association of Pennsylvania reports on its stewardship

IN TEN years of community service, the Medical Service Association of Pennsylvania increasingly has been accepted by the public of the State and by members of the medical profession as the best possible voluntary, prepaid medical care plan.

Growth in membership from 967 subscribers at the end of 1940, the first year of operation, to 556,693 on December 31, 1949, attests to the value of MSAP's protection against the costs of serious illness and injury. Only 144 members of The Medical Society of the State of Pennsylvania had become "Participating Physicians" by the end of 1940, but now there are 7846 doctors of medicine, 409 doctors of osteopathy, and 196 doctors of dental surgery, a total of 8451 "Participating Doctors" in the doctors' own plan.

Throughout the ten years, the Association steadfastly has held to its twofold purpose: "To provide the means of meeting the costs of certain professional services in 'catastrophic illness,' and to maintain the existing doctor-patient relationship, thereby assuring complete freedom of enterprise."

Supported by the Board of Trustees of the State Medical Society, legislation permitting the

establishment of "A Non-Profit Medical Service Plan" was passed by the General Assembly of 1939. Incorporation of MSAP as a non-profit organization under this act was made in the Dauphin County Court on September 3, 1939, but the Association actually came into being at a meeting of the incorporators on April 3, 1940.

Financial as well as legislative and leadership support for MSAP came from the beginning from the State Medical Society. The original \$25,000 on which the Association began business was loaned by the State Society. This amount and other advances were repaid from surplus in 1948. Literature distributed to the public has informed them that MSAP has been and is "sponsored by The Medical Society of the State of Pennsylvania."

Enrollment of subscribers began in the Pittsburgh area on October 1, 1940. Growth was very slow during the first few years, retarded particularly by World War II. At the end of the first five years there were only 26,740 subscribers, and most of them were located in the western part of the State. Today the more than 600,000 subscribers work and live in every one of the 67 counties.



Quarterly meetings are held by the MSAP Board of Directors to hear reports and to plan for the future. At the last meeting this photograph was taken, showing: Front row, left to right, John Kinneman, Jr., Pittsburgh, third vice-president; Lewis T. Buckman, M.D., Wilkes-Barre, second vice-president; J. Arthur Daugherty, M.D., Harrisburg, president; James Z. Appel, M.D., Lancaster, first vice-president; George H. Stein, M.D., Harrisburg, treasurer. Back row, left to right, Directors: C. L. Palmer, M.D., Pittsburgh; John T. Farrell, M.D., Philadelphia; Walter E. Burns, Harrisburg; Frederick B. Davies, M.D., Scranton; Robert Devereux, M.D., Wayne; Guy H. McKinstry, M.D., Washington; James L. Whitehill, M.D., Rochester; W. Stadden Williams, Harrisburg, and Roy W. Mohler, M.D., Philadelphia. Two other directors, Charles L. Brown, M.D., Philadelphia, and John E. Livingood, M.D., Rohesona, were absent when the picture was taken.

The valuable protection provided for these subscribers through the ten years is indicated by the fact that doctor bills amounting to \$5,222,249 have been paid by the Association. Payments to doctors have increased more than one hundred times from the paltry \$20,882 paid in 1941, the first full year of operation, to \$2,702,748 in 1949. This vast sum was paid on more than 50,000 Doctor's Service Reports.

The Association's growth has been reflected, too, in the increased benefits which have been added from time to time to provide greater protection for the subscribers. In the beginning only the Surgical Agreement covering in-hospital surgery and obstetrics was offered to subscribers. The Medical-Surgical Agreement adding coverage for medical cases in the hospital for 21 to 30 days a year was first offered in 1946, and later, the same year, obstetrical delivery in or out of the hospital was added. The next year the Medical-Surgical Agreement was broadened to cover surgery in or out of the hospital.

Last month MSAP announced its greatest increase in benefits ever made. Effective April 1, 1950, the extended coverage will include new

fees for surgical operations, payments for home and office calls for employed subscribers, longer payments for medical care for in-hospital patients, a fee for a bedside consultation, and an increase in first-day medical care payments.

Approval of MSAP's medical care plan came from the American Medical Association in 1946, permitting the Pennsylvania Plan to become the Blue Shield Plan in the State. At the same time, the Association became a charter member of Associated Medical Care Plans, the national association of Blue Shield plans. Today MSAP is the sixth largest of 67 Blue Shield plans operating in the United States and its possessions.

Acceptance of the Pennsylvania Blue Shield Plan is attested to not only by the rapid growth in members during recent years but also by replies to surveys which have been conducted. Last summer 95 per cent of those answering a questionnaire said they were satisfied with their Blue Shield protection.

To make further impact upon the public mind concerning the growing value of Blue Shield protection against the hazards of costly illness and injury, MSAP is conducting a vigorous enrollment and public relations program.

Back in 1941 the first offices of the Association occupied loaned quarters in the State Medical Society headquarters. Today MSAP has its own home office in a recently completed building on North Front Street in Harrisburg. It also maintains district offices in Philadelphia and Pittsburgh and has enrollment offices in Reading and Sunbury.

Through operating agreements with hospitalization plans in five areas of the State, the enrollment, billing, and fee collections of Blue Shield subscribers are handled by these plans, acting as agents for MSAP. All professional services and professional relations are maintained throughout the State by the Association. It also handles enrollment, billing, and fee collection in 17 counties in central and southern Pennsylvania.

The original incorporators of the Medical Service Association of Pennsylvania and all those who have served the Corporation and the Board of Directors through the ten years have had a vision of providing the best possible health security the voluntary way for the largest possible number of subscribers. In the future, as in the past, MSAP will give greater and greater value both to Blue Shield subscribers and to Participating Doctors.





President Harold E. Stassen (*left*) of the University of Pennsylvania, Philadelphia, recently was enrolled as the 500,000th member of the Medical Service Association of Pennsylvania. Presenting the Blue Shield Medical-Surgical Agreement to President Stassen is Roy W. Mohler, M.D. (*right*), Philadelphia, a member of the MSAP Board of Directors and Executive Committee, in the presence of Thomas F. Boon (*center*), manager of the MSAP Philadelphia district office. President Stassen joined the new Blue Shield group at the University, which includes members of the administrative staff and faculty and employees.

LOOKING AHEAD WITH BLUE SHIELD

By J. ARTHUR DAUGHERTY, M.D.

President, Medical Service Association of Pennsylvania

One important fact which the history of the Medical Service Association of Pennsylvania does not point out is that the doctors' own plan of voluntary prepaid medical care has been a solid bulwark against efforts to establish a nation-wide compulsory health insurance plan. For the more than 600,000 satisfied subscribers to the Blue Shield Plan in Pennsylvania, there has been no need for any other plan of medical care protection.

As MSAP continues to grow in membership, there will be an increasing number of the State's citizenry who will not only be a defensive but also an offensive group against any plan of socialized medicine. Their satisfaction with the voluntary way will make them vocal against the freedom-destroying evils of compulsory plans.

Members of The Medical Society of the State of Pennsylvania have played an important part in developing and supporting MSAP's Blue Shield Plan. On this tenth anniversary, it is my proud privilege to express deep appreciation on behalf of the Board of Directors to our participating doctors for a job well begun.

In the years ahead, MSAP will continue its efforts to provide the best possible voluntary health protection for an increasing number of Blue Shield subscribers. Your continued efforts to enlist the interest of your patients, your friends, and all with whom you come in contact will help materially to maintain the Blue Shield Plan as the best answer to the need for health security in Pennsylvania.

A Letter of Commendation

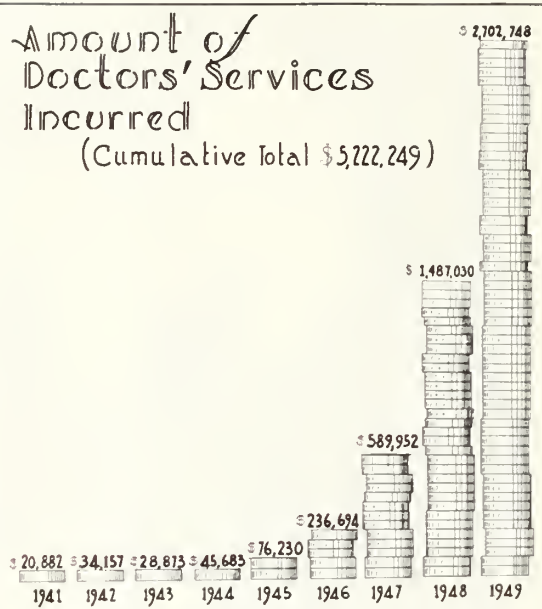
In behalf of The Medical Society of the State of Pennsylvania I wish to extend the Society's best wishes to the Medical Service Association of Pennsylvania on its tenth anniversary.

The early years of organizing Blue Shield in Pennsylvania were earmarked by growing pains which were natural. Now, with its phenomenal rate of growth and expansion, the Medical Service Association of Pennsylvania has earned its place among the leading Blue Shield Plans in America.

It gives me great pleasure to extend congratulations at this time because of what the Medical Service Association of Pennsylvania means to the medical profession. It has given the doctors of Pennsylvania an opportunity to serve more people, and has done much toward building an impregnable defense for organized medicine against those who would attack it.

As the Medical Service Association of Pennsylvania and The Medical Society of the State of Pennsylvania look ahead to many more years of cooperation and service, please accept our thanks for a job well done, and our very best wishes for the future.

E. ROGER SAMUEL, M.D., President,
The Medical Society of the State of
Pennsylvania.



MSAP Is Sixth Largest Blue Shield Plan

Ranking as the sixth largest of 67 Blue Shield plans in the United States and its possessions, MSAP reported the greatest percentage of membership growth (35.58 per cent) of the six largest plans during the first nine months of 1949, according to reports of the Associated Medical Care Plans. As of September 30, 1949, MSAP had reserves per member of \$2.75, the second highest among the six largest plans.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA STATEMENT OF CONDITION

December 31, 1949

<i>Assets</i>	
U. S. Treasury bonds	\$ 771,307.65
Home office building	112,755.60
Cash on hand, transit and deposit	1,443,353.97
Accrued interest	2,354.17
Prepaid expenses	23,557.60

TOTAL ASSETS \$2,353,328.99

<i>Liabilities and Reserves</i>	
Accounts payable	\$ 3,860.60
Subscribers' deposits	976.40
Prepaid subscription fees	277,984.19
Professional service reported but unpaid	29,026.25

TOTAL LIABILITIES \$ 311,847.44

Reserve for:	
Administrative expenses \$	18,276.00
Unreported professional services	361,800.00
Deferred maternity care	353,750.00
Contingencies	1,307,655.55

TOTAL RESERVES \$2,041,481.55

TOTAL LIABILITIES AND RESERVES \$2,353,328.99

* Market value \$778,400.00

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

FIVE-POINT CANCER DETECTION EXAMINATION

A five-point cancer detection examination form has been adopted recently by the Commission on Cancer. This form is designed primarily for use by the busy general practitioner who is unable to take the time to complete the previously adopted more complete examination form.

Although the shorter form is to be distributed statewide, the more complete examination form will continue to be used in the cancer detection examination centers.

Making these forms available to all practitioners of medicine is one of several steps which the Commission on Cancer is undertaking in its efforts to encourage cancer detection examinations in the office of the physician.

The form appearing below will be printed on a 5 x 8 filing card and copies may be requested from the secretary of the Commission on Cancer, The Medical Society of the State of Pennsylvania, 230 State Street, Harrisburg.

FIVE-POINT CANCER DETECTION EXAMINATION

(Record Only Positive Findings)

Name	Age	Sex
Address	Date	
SKIN: Warts	Moles	FEMALE GENITALIA:
Pigmented		Vulva:
Growing		Leukoplakia
Subject to irritation		Ulcers
Senile keratoses		Circumscribed swellings
Melanomata		Cervix:
ORAL CAVITY: Ulcers		Erosions
Swellings		Polyps
Leukoplakia		Ulceration
BREASTS: Lumps		Friable masses
Nipples: Inverted		Contact bleeding
Discharging		Uterus—enlargement
Orange peel skin		Bleeding from external os
OTHER ABNORMAL PATHOLOGY:		Adnexal masses
.....		RECTUM: (examine with gloved finger, preferably
.....		after enema)
.....		Polyps
.....		Thickening of wall
.....		Nodular masses
.....		Prostate
.....		CANCERS DETECTED:
.....		

Please report once each month the number of patients examined and the number of cancers detected.

Last Chance to Register for—

Special Electrocardiography Course

Nurses' Auditorium, Harrisburg Hospital, Harrisburg

To be presented on seven consecutive Thursdays from 9 a.m. to 4:30 p.m.

May 11, 18, 25, June 1, 8, 15, and 22, 1950

Registration fee \$35.00—Registrations limited to 60

42 Hours of Intensive Instruction

Presented by the Commission on Graduate Education of

The Medical Society of the State of Pennsylvania

Enroll now before the quota is filled—use the form below

Special Electrocardiography Course Registration Form

TO THE COMMISSION ON GRADUATE EDUCATION,
230 State St., Harrisburg, Pa.

Please enroll me in the Electrocardiography Course to be given in the Nurses' Auditorium of the Harrisburg Hospital, Harrisburg, on Thursdays, May 11, 18, 25, June 1, 8, 15, and 22, 1950.

I am enclosing my check for \$35.00 made payable to The Medical Society of the State of Pennsylvania for my registration fee.

Name (print in full)

Street

City

Specialty (if any)

Signed _____, M.D.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*
8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

COUNTY HONOR ROLL FOR 1950

In the February PENNSYLVANIA MEDICAL JOURNAL we had the privilege of reporting that 3741 members of The Medical Society of the State of Pennsylvania from 32 county societies had, before February 1, paid their combined county, state, and AMA dues. Reporting on dues paid six weeks later, it is pleasing to show that 8300 members from 47 county societies have paid.

How can this grand showing be interpreted as reflecting anything but dynamic action on the part of county society officers, and remarkable and prompt display of unity and loyalty by more than half of the active members of the State Society. If, at the time of reading these lines, you have not paid your 1950 dues, please do so at once, thereby retaining without interruption your medical defense coverage and sparing county, state, and AMA officers from unnecessary book-keeping, correspondence, and postage.

Watch for the May honor roll with its comparative chart showing final dues payments, county by county, on a percentage basis.

delinquency and dropped for non-payment. All of our 1949 members are currently 1950 AMA members. They should either pay the latter dues or send a letter of resignation to 535 North Dearborn St., Chicago 10, Ill. To merely fail to pay 1950 AMA dues will result in delinquency and the spoiling of an otherwise good membership record.)

"A Member Fellow shall pay annual dues not to exceed twelve dollars as may be determined by the Board of Trustees and announced in the *Journal of the American Medical Association*. Dues shall include subscription to either the *Journal of the American Medical Association* or any special scientific journal published by the Association. Dues shall be payable in advance on January 1 of each year."

"SERVICE FELLOWS—On approval of the Judicial Council, commissioned medical officers of the United States Army, the United States Navy, the United States Air Force, or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration, who have been nominated by its Chief Medical Director, may become Service Fellows. Such Fellows shall have the same rights and privileges as Member Fellows, but shall not be required to pay dues and shall not receive any publication of the American Medical Association except by personal subscription. Service Fellows shall retain Fellowship as long as they are on active duty and thereafter if they have been retired in accordance with Federal law and do not engage in active practice."

AMA FELLOWSHIP

So many inquiries are received by the Secretary-Treasurer regarding AMA Fellowship that the appended has been prepared in brief form from the AMA Constitution and By-Laws as a guide for JOURNAL readers:

"MEMBER FELLOWS—Active members of the Association who have made proper application to the Secretary and who are approved for Fellowship by the Judicial Council shall be Member Fellows. A Member Fellow shall retain his Fellowship as long as he is an active member of the Association."

(SECRETARY'S NOTE: *Active AMA members do not become delinquent for non-payment until the end of the calendar year, at which time they will be notified of*

"ASSOCIATE FELLOWS—Physicians (1) who have been Member or Service Fellows continuously for not less than fifteen (15) years and are not less than sixty-five (65) years of age, or (2) who are members of their component societies and their constituent associations, but are relieved from the payment of the dues or fees imposed on active members, may be nominated for Associate Fellowship. They shall be nominated by their constituent associations to the Council on Scientific Assembly for consideration and recommendation to the House of Delegates and shall become Associate Fellows when they receive a majority vote of the House of Delegates.

"Associate Fellows shall be privileged to participate in the Scientific Assembly. They shall not be required to pay Fellowship dues and shall not receive any publication of the Association except by personal subscrip-

tion. They shall continue as Associate Fellows only as long as they maintain their relationship with their constituent associations as prescribed in this section."

In addition to the above, Chapter IV, Section 1, makes provision for Affiliate Fellows:

"AFFILIATE FELLOWS—

- (1) Members of the chartered national medical societies of foreign countries adjacent to the United States.
- (2) American physicians located in foreign countries and engaged in medical missionary and similar educational and philanthropic labors.
- (3) Dentists.
- (4) Pharmacists.
- (5) Teachers of medicine or of the sciences allied to medicine who are citizens of the United States and are not eligible to membership."

[EDITOR'S NOTE: Nominations for Affiliate Fellowship should not be suggested before obtaining details on procedure.]

"HONORARY FELLOWS—Physicians of foreign countries who have risen to pre-eminence in the profession of medicine and who are in attendance at the session may be elected to Honorary Fellowship by the House of Delegates on the nomination of the Council on Scientific Assembly."

UNION LABOR'S GRATIS ADVICE

On page 2 of the *Pennsylvania Federationist*, official monthly bulletin of the Pennsylvania Federation of Labor, under a superimposed cartoon are bold headlines: "AMA to Intensify Drive Against Health Insurance Program: Assess Doctors \$25." The cartoon consists of a giant, designated as "AMA," leaning over a contribution box labeled "We don't want your viewpoint, just your 25 bucks." In the background are the following signs: "Donate or Out You Go" — "AMA's Campaign Against National Health" — "Voluntary Donations Are Now a Must!!" Looking up at this giant is a small individual entitled "Doctors."

There follows an emphatic criticism of the AMA's request for this donation together with criticism of the AMA's Education Campaign. These are rather time-worn statements intended to divide the profession, and are used frequently so that certain organizations may advance their own cause.

In the upper left-hand corner of page 8 is the caption "Harrisburg C.I.U. and Teamsters Council Endorses Senator Myers"; below that, "Union's Money Can Be Used for Local Candi-

dates." It is indicated that only funds contributed voluntarily may be used to help elect a congressman or a senator, but funds from union treasuries may be freely used in behalf of *registration campaigns*, get-out-to-vote campaigns, also the election of state and local candidates, such as assemblymen and councilmen. In the right-hand column of the same page the following paragraphs appear:

"TIP TO DOCTORS"

"We would like to give the average well-meaning doctor a little tip from our experience. We are amateur politicians too. We have learned that you had better not flex your muscles in front of John Q. Public and Joe D. Congressman unless you can deliver. Remember, for every doctor there are a thousand patients—WHO VOTE.

"Your 1,000,000-a-year lobby team is not only overselling your case; it is also bringing discredit to an honored profession. And as sure as night follows day, its disreputable tactics will anger the public and Congress into calling for the very legislation you abhor. Think it over."

This is certainly inconsistent. In the first paragraph quoted above, the publication endeavors to give the medical profession political advice and refers to us as "amateur politicians." The history of the State Medical Society reveals that the membership of the Society has been actively interested in public affairs since its origination in 1848. As a result of the State Medical Society's activities in public health and legislative affairs, the State Board of Health was created, which eventually became the State Department of Health. Doctors were registered in 1878; in 1893 the Council on Medical Education was created; and in 1911 the State Board of Medical Education and Licensure was authorized. Many other legislative measures have been enacted more recently through the efforts of the State Medical Society and its component county societies. For example, in 1937 the Public Assistance Law was amended to include medical service to the indigent; in 1939 provision was made for the creation of the Medical Service Association of Pennsylvania (MSAP), which is now a going concern and offers to low or middle income groups and individuals limited surgical, obstetrical, and medical services at a low premium rate in conjunction with Blue Cross.

These and many other activities have been indulged in for the interest of the public by The

Medical Society of the State of Pennsylvania for years.

The legislative activities of this society precede by many years the very active part played more recently by labor organizations; therefore, it is difficult to understand their classifying us, with them, as "amateurs."

It seems in this activity that everyone is "out of step" except the A. F. of L.

If labor desires to develop a medical service plan such as the plan adopted by the LGW or the United Mine Workers, in which the medical profession cooperated wholeheartedly, we will be perfectly willing to cooperate in a similar effort, providing the procedures are along traditional and ethical lines.

C. L. PALMER, M.D.

A SCHOLARSHIP FUND

Money from the Educational Fund of The Medical Society of the State of Pennsylvania is now available for children who, through death or incapacitating illness or injury of the physician parent member of this Society, can qualify satisfactorily for college entrance.

It should be remembered that there may be widows of deceased members with children of recent or early high school graduating age who will have little knowledge of the existence of the Society's Educational Fund, and less knowledge that its benefits are now ready for consideration.

Copies of the application form may be had by writing to the Educational Fund Committee, The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

OPPORTUNITIES FOR CIVILIAN MEDICAL PERSONNEL IN PACIFIC ISLANDS

From the office of the Secretary of the Department of the Interior it is learned that, as of July 1, 1951, naval officers and enlisted personnel serving in U. S. Pacific Island governments will be replaced with civilians selected before the transfer dates. Each island area has hospital facilities, small island or village dispensaries, and public health organizations. Medical work in these islands, in view of the great need for health services, the varied nature of medical problems, and the differing cultures of the people, offers an important challenge to doctors and other medical personnel.

In establishing medical positions for the governments of these areas, the Department of the Interior will follow federal classifications, but applicants need not be on a Civil Service register to be eligible for appointment. Salaries for doctors will range from \$6,400 to \$8,800 per annum.

Detailed information regarding opportunities for health work in the Pacific Islands may be obtained from the Division of Territories and Island Possessions, Department of the Interior, Washington 25, D. C.

MEDICINE'S ROAD AHEAD*

"It is critically important that American doctors do everything in their power this year to stop the march of Socialism in this country—and to stop it at the polls by aiding in the election of Congressmen who will refuse to compromise on American principles.

"Legally, however, it is imperative that doctors who engage in active support of candidates do so as individual citizens—and not under the auspices of their medical societies.

"No county, state, or national medical society can either legally or ethically support or oppose candidates for public office.

"Medical societies are prohibited from endorsing a candidate, from contributing funds to any candidate for Federal office, from using medical society letterheads or facilities to advance work in behalf of a candidate, and from signing newspaper advertising in behalf of a candidate, or sponsoring any other form of advertising material for a candidate.

"It is the right and duty of every citizen to aggressively further the candidacy of any qualified candidate for Federal office and actively oppose the candidacy of any candidate felt to be unqualified.

"Any group of citizens, whether on a national, state, or county level, can as individuals form political action committees for this purpose.

"Effective doctor-participation in election campaigns—

"What can they do that will mean votes at the polls on election day?

"The leadership in political action committees

* An excerpt from an address by Clem Whitaker during the Second National Conference, AMA National Education Campaign, held in Chicago, Feb. 12, 1950.

of organized doctors should come from leaders in medicine in every section of the country. But the personal work of the rank and file must be made to count on election day.

"There shouldn't be a doctor in this country who doesn't register and vote this year—and there shouldn't be any member of a doctor's family who fails in this basic responsibility.

"The doctor who doesn't vote this year is not only letting down his profession, and all the men in public life who have championed medicine's cause; he is also letting down his country and inviting destruction of the system he lives by. . . .

"Without doubt the most effective single job that doctors can do in a Congressional campaign, in most districts, is a thoroughgoing letter-writing job, beamed to their patients—personal letters signed by the doctor on his professional letterhead, and mailed in his own envelopes.

Political action committees which lend their support to candidates for Federal office must be independently organized by individual doctors. They cannot, in any sense, be subsidiaries of medical societies."

DPA INVESTIGATES MEDICAL CARE PROGRAM

To the 26000 Pennsylvania Doctors Participating in the Medical Care Program of the Department of Public Assistance:

Information has come to the State Healing Arts Advisory Committee to the Pennsylvania Department of Public Assistance that a quiet investigation has been going on for some time by this department of irregularities in practice and procedure alleged to be of a criminal nature (fraud) indulged in by physicians, osteopaths, dentists, druggists, nurses, and clinics participating in the Medical Care Program.

Articles in the newspapers (Pittsburgh *Post Gazette* and *Press* of Saturday, January 28, and *Press*, Sunday, January 29) indicate that this investigation of alleged chiseling "was ordered by Governor Duff through the Department of Public Assistance, the State Police, the Auditor General's office, the Joint State Government Commission, and the Attorney General's office." It should be noted that Public Assistance Secretary Frank A. Robbins is quoted as follows: ". . . such information is inclined to be treated

sensationally and he 'wants to protect the many doctors who are guilty of no wrongdoing.'"

The State Healing Arts Advisory Committee representing the participating professional groups welcomes such an investigation, and if irregularities of any kind are definitely proved by facts, the committee will do all it can to eliminate "chiseling."

It is unfortunate that the governmental authorities did not choose to follow the control system agreed upon and accepted twelve years ago by the Department of Public Assistance and the State Healing Arts Advisory Committee which provides that any such irregularities are to be reported to the State Healing Arts Advisory Committee and through it to the proper county healing arts advisory committee for disciplinary action.

This has been done successfully in several instances and, if followed in this instance, might have "nipped in the bud" irregularities complained of and have thus saved considerable expense to the taxpayer in the projected investigation and court procedure.

Since the policy of the governmental authorities is to quietly investigate this alleged chiseling, the opportunity presents itself *to again advise all participants in the program to be extremely careful* in making out their invoices and in their professional practice under this program in order to avoid a destructive effect on the entire program, and, at the same time, prevent any possible court action against themselves.

In the case of doctors of medicine, a court conviction may lead to the possibility of the individual's license being suspended or revoked as provided for in the Medical Practice Act.

Please inform immediately, by the most expeditious method, all participating physicians in your county—totaling throughout the State about 2500.

Yours truly,

C. L. PALMER, M.D., *Medical Representative*,
State Healing Arts Advisory Committee,
Jan. 30, 1950

SALARIED INTERNSHIP

Selection of senior medical students for the Army's civilian intern program is proceeding at an accelerated rate since the first of this year, Major General R. W. Bliss, the Army Surgeon

General, said recently. To date, 52 applicants have been selected from 34 of the country's approved medical schools and will intern in 48 different civilian hospitals. To be eligible a candidate must be a potential graduate who will begin an internship between Jan. 1 and Dec. 31, 1950, and must have been accepted for internship training in a civilian hospital acceptable to the Surgeon General. Successful candidates will be commissioned in the Army Medical Corps Reserve and permitted to complete their internships as officers on active duty with pay and certain allowances of the grade of first lieutenants. Physicians selected must serve two years on a duty status for the year or major portion of a year of formal training received.

PUBLIC ASSISTANCE MEDICAL SERVICE

At the December meeting of the Montgomery County Medical Society, Albert R. Garner, M.D., chairman of the County Healing Arts Advisory Committee, reported as follows for the month of October, 1949: "131 physicians received \$3,448 for 668 patients and 540 invoices. The pharmacists were paid \$1,377.77; the nurses, \$475.95; the dentists, \$321.75; and the clinics, \$308."

At the January meeting Dr. Garner also reported that state Public Assistance "paid 120 physicians \$2,755.50 for the month of November. The pharmacists received \$1,476; 14 nurses, \$485.20; dentists, \$404.75; and clinics, \$225.50.

At this meeting it was also reported that in the mass x-ray program put on in Lower Merion Township and the Borough of Narberth, in which 14,646 tests were made, "150 suspected cases of tuberculosis were found and, on follow-up, 109 of these were confirmed."

EXCERPTS FROM MINUTES OF MEETINGS OF BOARD OF TRUSTEES AND COUNCILORS

Sept. 25, 1949

The Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania met on Sunday, Sept. 25, 1949, in the Hotel William Penn, Pittsburgh.

Members in attendance were: Drs. Hugh M. Miller (1st), John J. Sweney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altamus (11th), and Thomas R. Gagon (12th).

Officers present were: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer;

E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and Park Berkheimer, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Howard K. Petry (Public Relations), Louis W. Jones (Medical Economics), Elmer Hess (Hospital Relations), and Executive Secretary Lester H. Perry and other staff members.

Chairman Lorenzo called the meeting to order at 10:40 a.m.

The minutes of the July 14-15 meetings were approved as corrected.

No new medical defense cases were reported.

The report of the Finance Committee included detailed budget information for the ensuing year. The Board authorized the sale of the bonds in the Social Security Tax Reserve Fund, the proceeds to go to the General Fund.

Progress reports were presented by the Building, Publication, and Library Committees.

Report of the President: Dr. Engel reported on a meeting with the American Legion in Philadelphia, August 27, with Mr. Tom Hendricks and Dr. W. W. Bauer of the AMA also present, ending with the comment that too few influential medical men are members of the American Legion.

President Engel reported also on progress in setting up the Pennsylvania Health Council and enlisting all agencies and groups interested in health projects. More than 30 organizations were represented at the first meeting. Three committees on Organization, on Projects, and on Nomination of Permanent Officers were appointed. Dr. Engel said that the organized profession had a rather successful year on the national level, but it must not be lulled into relaxation. He extended sincere thanks for support during the year.

The Board extended to Dr. Engel a vote of sincere thanks in appreciation of his service as president.

Report of President-elect Samuel: Dr. Samuel reported being engaged in choosing the personnel of seven reference committees for the House of Delegates and of the Society's 37 committees and commissions; he attempted to get all of these in order before the annual meeting. Enough acceptances had been received to assure that any committees or commissions desiring to meet during this session could do so and obtain an early start on the year's work. The committees with personnel incomplete were principally those to be approved by the Board of Trustees, namely, Public Relations, Public Health Legislation, and Medical Economics.

Dr. Samuel suggested that next year the installation meeting be held on Monday rather than Tuesday night; he said the incoming president should have two days with the House of Delegates in which to propose his suggestions and his ideas for the coming year. Dr. Samuel was invited and expected to attend the celebration of the 100th anniversary of the Indiana State Medical Society in Indianapolis on Thursday evening.

The Board unanimously accepted the report of the president-elect.

The Board approved the report of the Committee on Public Health Legislation.

During the report of the Committee on Public Relations, Chairman Petry advised that the Society take a positive position on the 1948 survey of public health service in Pennsylvania, stating that we should be formulating our program. Dr. Klump said that all voluntary health organizations are looking to our state medical society to take the lead in determining what shall be done about the recommendations of this survey.

The Board accepted the report of the Committee on Public Relations.

The meeting was recessed for lunch and reconvened at 2:30 p.m.

Unfinished Business—Presentation of 50-Year Testimonials to Non-members: A motion prevailed that anyone who has been in the practice of medicine for 50 years, whether or not he has been a member of the MSSP, if he has been approved by the component medical society of the county in which he resides, shall receive the State Society's 50-year award, and it was moved that the action be retroactive. (Vote on the motion: 6 for, 3 against, Dr. Gagon wishing to be recorded by name as having voted No.)

New Business—Election of Associate Members: Secretary Donaldson presented the names of four members duly nominated by their respective county societies who were elected associate members: Dauphin County, John Adam Sherger; Lackawanna County, John J. Bendick; Northampton County, Glenn G. Klock and Clair G. Harmon.

Before adjournment to attend the Religious Hour, the Board decided to meet Monday, Sept. 26, 1949, at 1 p.m.

FRANK A. LORENZO, M.D., *Chairman,*

WALTER F. DONALDSON, M.D., *Secretary-Treasurer.*

Sept. 26, 1949

The Board of Trustees and Councilors reconvened on Monday, Sept. 26, at 1:15 p.m. in the Hotel William Penn.

Dr. Pascal F. Lucchesi, chairman of the *Commission on Preventive Medicine and Public Health*, presented a resolution adopted by his commission regarding publicity about several chapters of the *Keystones of Public Health Survey*, after study by his commission as well as by certain other state society control committees.

By unanimous action the Board approved this resolution, together with its recommendations, to be promptly presented to the House of Delegates as a supplemental report from the Board of Trustees.

AMA Dues: The Board adopted a resolution for presentation to the House of Delegates favoring the establishment of annual dues for members of the AMA, and instructing the Pennsylvania delegates to the Interim Meeting of the American Medical Association House of Delegates to support the establishment of dues for membership in the American Medical Association.

The report of a *Combined Committee of MSAP and MSSP*, as presented by Dr. Buckman, discussed new income limits for subscribers. Amendment of the

MSAP enabling act was accomplished through the Committee on Public Health Legislation with the permission of the Board of Trustees. These changes in income limits were made by MSAP after acceptance by the Board of Trustees and with the authority of the Pennsylvania Commissioner of Insurance.

The report of the Combined Committee was on motion accepted, with Dr. Gagon voting in the negative.

The Secretary-Treasurer stated that the problem of displaced physicians would not be settled until a report was brought in next June by a previously appointed committee of the AMA.

Amendment to VA Fee Schedule: Dr. Jones, chairman of the Committee on Medical Economics, presented a brief report in regard to the proposed amendment to Veterans Administration contract V1001M-266, which was discussed with the chairman of the Commission on Physical Medicine and recommended to the Board.

By unanimous action the report was adopted.

The Board adjourned to reconvene Tuesday, September 27, at a time when the House of Delegates was not in session.

FRANK A. LORENZO, *Chairman,*

WALTER F. DONALDSON, *Secretary-Treasurer.*

Sept. 27, 1949

The Board of Trustees and Councilors reconvened Tuesday, September 27, at 2:15 p.m., in the Hotel William Penn.

The Secretary read a telegram from Dr. Joseph S. Brown explaining his absence from the meetings due to illness, and stated that Dr. Charles V. Hogan had been unable to attend this and the Monday afternoon meetings due to the fact that he had to be present in Schuylkill County at a court trial.

The Board discussed the 1949-50 budget in executive session, at which time the following actions were taken:

1. The *Finance Committee* was given authority to borrow \$35,000 from the Medical Defense Fund, paying 3 per cent interest, and to file with a "safe keeping" depository a promissory note covering same. The proceeds are to be used for the Building Fund, and the loan is to be reduced annually at a minimum rate of \$5,000 per year. The motion carried by a vote of 6 to 3.

2. *State Society dues* for 1950, as recommended to the House of Delegates, will be \$23, of which \$1.00 will be allocated to the Medical Benevolence Fund and \$2.00 to the Educational Fund. Dr. Gagon wished to be recorded by name as having voted in the negative.

The meeting adjourned at 4 p.m. to reconvene for luncheon and a business meeting following adjournment of the House of Delegates on Wednesday.

FRANK A. LORENZO, *Chairman,*

WALTER F. DONALDSON, *Secretary-Treasurer.*

(SECRETARY'S NOTE: Most of the Board's actions mentioned were referred to the House of Delegates and actions thereon appear in the minutes of the 1949 House of Delegates published in the December PENNSYLVANIA MEDICAL JOURNAL. Other Board actions were based on reports presented which appear in full with all Board

minutes as they are filed in the Harrisburg and Pittsburgh offices of the Society and in the office of the Philadelphia County Medical Society. These are available for inspection by members of The Medical Society of the State of Pennsylvania.)

Sept. 28, 1949

The Board convened at 2 p.m. for its fourth and last meeting during the Society's ninety-ninth annual session in the Hotel William Penn, Pittsburgh.

Members in attendance were: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th).

Officers and newly elected Board members present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; Gilson Colby Engel, trustee and councilor, First District; and Robert P. Banks, trustee and councilor, Sixth District.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Howard K. Petry (Public Relations), and Mr. Lester H. Perry and Mr. A. H. Stewart, Jr., of the Harrisburg office.

Presentation of Officers: Chairman Lorenzo then presented to the Board the new president-elect, Dr. Harold B. Gardner, and the two new trustees and councilors, Drs. Gilson Colby Engel, First Councilor District, and Robert Parker Banks, Sixth Councilor District.

Dr. George S. Klump was elected chairman.

The Board, by a unanimous and rising vote, extended expressions of thanks and deep appreciation to Dr. Frank A. Lorenzo for his services as chairman of the Board during the past year.

Dr. Thomas R. Gagon was elected *vice-chairman* of the Board.

The Board then proceeded with the election of: *editor*, Dr. Walter F. Donaldson; *executive secretary*, Mr. Lester H. Perry; *convention manager*, Mr. Alex H. Stewart, Jr.; *legal counsel*, Evans, Bayard and Frick, of Philadelphia.

This was followed by successive actions determining salaries of office and stenographic assistants in the Harrisburg and Pittsburgh offices.

Dr. John J. Sweeney was reappointed to the *Advisory Committee on Medical Service* to the Middle Atlantic States Regional Conference.

Appointment of Committee on Public Health Legislation: President Samuel then read the names of his proposed appointees to the Committee on Public Health Legislation. The appointments were officially confirmed.

By action of the Board, Dr. Louis W. Jones, first vice-president, was assigned to the Board of Trustees and Councilors; Dr. Louise C. Gloeckner, second vice-president, to the Committee on Public Relations; Dr. Mark K. Gass, third vice-president, to the Committee on Public Health Legislation; and Dr. L. Dale John-

son, fourth vice-president, to the Committee on Medical Economics—all *ex officio*.

The proposed budget for the new fiscal year, as distributed to Board members three weeks in advance, was, with a few changes, accepted.

Request from Philadelphia County Delegates: After conference with the chairman of the Finance Committee, the Board authorized the Secretary-Treasurer to mail to the entire membership a brief explanatory letter regarding the Society's present finances, including a statement of the need for the increased dues.

Appointment of Board Committees: The following committee appointments were announced: *Finance:* Drs. James L. Whitehill, chairman, Herman H. Walker, and James Z. Appel. *Publication:* Thomas R. Gagon, chairman, Leard R. Altemus, and Charles V. Hogan. *Building Maintenance:* Francis J. Conahan, chairman, Gilson Colby Engel, and John J. Sweeney. *Library:* Frank A. Lorenzo, chairman, and Robert P. Banks. *Medical Benevolence:* E. Roger Samuel, chairman, Walter F. Donaldson, secretary, Francis J. Conahan, treasurer, and Laurie D. Sargent. *Educational Fund Committee:* James L. Whitehill, chairman, Elmer Hess, Louise Gloeckner, and Walter F. Donaldson.

The Board adjourned to meet in Harrisburg on December 8 and 9. The meeting was adjourned at 3:45 p.m.

GEORGE S. KLUMP, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Dec. 8, 1949

The Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania met at 9 p.m., Dec. 8, 1949, in the Hotel Harrisburger, Harrisburg.

Members in attendance were: Drs. Gilson Colby Engel (1st), John J. Sweeney (2d), Francis J. Conahan (3d), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), James L. Whitehill (10th), and Leard R. Altemus (11th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Malcolm W. Miller, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Howard K. Petry (Public Relations), Dudley P. Walker (Medical Economics), Charles Wm. Smith (Graduate Education), and Messrs. Lester H. Perry, executive secretary; A. H. Stewart, Jr., convention manager; Leo E. Brown and Robert L. Richards, of the Harrisburg office.

Call to Order: Chairman Klump introduced to the Board Drs. Dudley P. Walker, chairman of the Committee on Medical Economics, and Malcolm W. Miller, newly elected assistant secretary-treasurer.

Minutes of meetings held September 25 to 28 were approved as corrected.

Formal Approval of Ballots by Mail: Secretary Donaldson advised that on the ballot by mail regarding ac-

ceptance of the bids of the contractors on remodeling the headquarters buildings, 226 and 230 State Street, all members of the Board had voted favorably. The bids were formally approved.

Chairman Whitehill of the *Finance Committee* reported the maturing of a \$10,000 U. S. Savings Bond in the Medical Defense Fund. The Secretary-Treasurer was authorized to reinvest that amount and \$5,000 additional from the Medical Defense Savings Account in U. S. Savings Bonds "G." The report of the Finance Committee as distributed was adopted.

The Board approved the report of the *Publication Committee* as read by Dr. Altemus in the absence of Dr. Gagon.

The Board approved the report of the *Building Maintenance Committee* as read by Dr. Sweeney, after which Mr. Perry commented briefly on the progress of the remodeling of the headquarters buildings.

The Board approved the report of the *Library Committee* as distributed by mail.

No new medical defense cases were reported.

President Samuel reported his attendance, during September, in Indianapolis, at the centennial celebration of the Indiana State Medical Association; in October, at Sayre, the celebration of the centenary of the Bradford County Medical Society; and, in November, at Bethlehem, the celebration of the centennial of the Northampton County Medical Society. Both the latter were marked by good attendance and appropriate programs.

President Samuel recommended that the Board give due attention to the proposal for Grievance Committees in Pennsylvania to consider certain types of complaints against the profession.

President-elect Gardner reported having made a few appearances in the western part of the State, among them a meeting of the National Transportation Association held in Pittsburgh; a meeting of the Committee on Public Relations in Harrisburg, where he reported, at the request of Chairman Petry, the encouraging fact that he had received a check from a Pittsburgh layman in the amount of \$2,000 intended for the AMA National Education Campaign Fund.

Following a free discussion of the *Grievance Committee* proposal, the Board authorized the chairman to appoint a committee to study the different plans, and to report at the March board meeting on how to activate this problem, using the Board of Trustees and the Committees on Public Relations and Medical Economics; also recommended that the secretaries and presidents of county medical societies be advised that, while such a committee is being formed and is studying the matter, such lay grievances should be referred to the county society board of censors for hearings. Chairman Petry was advised that the Committee on Public Relations should give this information due publicity.

Chairman Klump then appointed the following committee: Drs. Louis W. Jones, chairman, James Z. Appel, Walter F. Donaldson, and Howard K. Petry.

At the suggestion of Mr. Perry, the Board authorized Chairman Klump to appoint a member to represent the State Society on the Committee on National Legislation of the Pennsylvania State Chamber of Commerce. Dr. Klump appointed Dr. C. L. Palmer.

Chairman Charles Wm. Smith, reporting for the *Commission on Graduate Education*, asked for an allotment to the commission of a given amount of money in addition to the registration fees collected. Chairman Whitehill of the Finance Committee mentioned the amount of the commission's budget and promised it a quarterly report of expenditures charged against it.

Chairman Smith reported that at its last meeting the Commission on Graduate Education had approved a form of *certificate* which attests that The Medical Society of the State of Pennsylvania's Commission on Graduate Education formally awards same to the individual named thereon for attending three years of instruction (220 hours) under the auspices of the commission, the certificate to be signed by State Society officers and the deans of the medical schools of Pennsylvania. The commission also proposed a proper "graduation" program at each annual convention. After the 1950 initial awards to 300 "graduates," there should be 30 to 50 who will qualify each year for similar certificates.

Secretary Donaldson suggested that the ceremonial *presentation of the certificates* and Dr. Peabody's essay on "Care of the Patient" be made a part of the Tuesday night Installation Meeting program at Philadelphia.

The Board unanimously accepted Dr. Smith's report and advised that the plans for the convention meeting at which the certificates would be presented be developed in conference with Dr. Donaldson and Mr. Stewart.

Chairman Smith then requested approval for repetition of the highly successful *course in electrocardiography* during the spring of 1950. Same was granted, together with the thanks of the Board for outstanding accomplishments.

Report of Committee on Medical Economics: Chairman Dudley P. Walker distributed to Board members copies of a report given by Dr. Warren F. Draper, medical director of the Medical, Health and Hospital Program of the United Mine Workers Welfare and Retirement Fund (UNMWA).

The meeting adjourned at 11:30 p.m. to reconvene at 9:15 o'clock the next morning.

GEORGE S. KLUMP, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Dec. 9, 1949

The Board reconvened at 9:15 a.m., December 9, in the Hotel Harrisburger, Harrisburg.

Members in attendance were: Drs. Gilson Colby Engel (1st), John J. Sweeney (2d), Francis J. Conahan (3d), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), James L. Whitehill (10th), and Leard R. Altemus (11th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Malcolm W. Miller, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Howard K. Petry (Public Relations), Dudley P. Walker (Medical

Economics), Pascal F. Lucchesi (Preventive Medicine and Public Health), and Messrs. Lester H. Perry, executive secretary, Leo E. Brown, and Robert L. Richards, of the Harrisburg office.

Secretary Donaldson presented a brief *summary of actions taken by the 1949 House of Delegates* which were referred to the Board of Trustees for implementation: (1) *Lancaster County Society resolution* endorsing Blue Cross and Blue Shield phase of June report of AMA Committee on Hospitals and the Practice of Medicine. This report was later recalled by AMA Interim House of Delegates in December, 1949. (2) *Review of 1948 Survey—Keystones of Public Health for Pennsylvania*. (3) *President Engel's address*, particularly that section pertaining to the over-all committee program with the creation of a master disease control committee. The reference committee advised that a special committee of the House of Delegates be appointed to study important proposals from the retiring president's address (see page 1715, December PENNSYLVANIA MEDICAL JOURNAL).

President Samuel then appointed the following committee to study the over-all committee setup as recommended by retiring President Engel: Drs. Thomas W. McCreary, *chairman*, Herman A. Fischer, Jr., Theodore R. Fetter, Henry F. Hunt, and Augustus S. Kech.

Chairman Klump announced that the *Commission on Preventive Medicine and Public Health* assumed that the assignment of the various chapters of the Survey report for study by various committees of the Society was its prerogative—the commission to channel such reports back to the Board.

Chairman Palmer's report of the *Committee on Public Health Legislation* consisted of (1) the minutes of the committee meeting held on November 30; (2) a statement to be turned over to the Committee on Public Relations for them to edit; (3) Chiropractic Act No. 525 which provides for a Board of Chiropractic Examiners already appointed by the Governor (the committee's legal counsel holds the opinion that this act is unconstitutional, and Dr. Palmer suggested that it might be well to consider the advisability of determining through the courts the constitutionality of this act); (4) discussion of the lobbying act during the AMA convention in Washington, D. C., at a meeting of lawyers representing several state medical societies. They agreed that the representatives of the state societies who had to do with health legislation should register as lobbyists.

Dr. Palmer was given authority to register in Washington, D. C., as a representative of the MSSP and his report was approved.

A ten-minute recess followed for showing a fine public relations film entitled "To Your Health" depicting laymen in dialogues against socialized medicine.

Report of Committee on Public Relations—Film on Socialized Medicine: Chairman Petry commented briefly on the cost of this film (outlined on page 3 of the committee's distributed report).

Public Relations Survey: Dr. Petry reported some very good ideas obtained from the Ketchum survey and

report, but it fell short of what the committee desired. He is much more in favor of the plan of Americans for the Competitive Enterprise System, Inc. He said that we must consider the other fellow's public relations problem as well as our own.

The committee's proposed change in *Benjamin Rush Award* rules and regulations was approved.

Chairman Klump read parts of a letter from Dr. Gagon regarding his inability to be present.

Dr. Howard K. Petry, chairman of the Committee on Public Relations, announced that on his doctor's advice he was resigning as chairman, but would continue to serve as a member of the committee.

Dr. Engel said: "I think our Public Relations Committee has been outstanding in the United States and that such success is not attained without an exceedingly competent leader. Dr. Petry has served the Society well and I think this Board should go on record as expressing sincere thanks and deep appreciation to him for a job well done for his fellow men."

(It was the consensus that Dr. Engel's remarks expressed the sentiment of the entire Board of Trustees.)

President Samuel requested suggestions to consider in naming a successor to Dr. Petry, who is also chairman of the Advisory Committee to the Woman's Auxiliary.

It was agreed that President Samuel and Dr. Petry should approach Dr. Allen W. Cowley regarding his acceptance of the chairmanship of the Committee on Public Relations.

Dr. Engel reported on the incorporation of *Americans for the Competitive Enterprise System, Inc. (ACES)* and requested that literature from the Public Relations Department of the MSSP be sent to Mr. Curtin Winsor, executive director of ACES.

Dr. Engel also reported that the *Pennsylvania Health Council* had adopted by-laws which have been officially approved by the boards of the National Foundation for Infantile Paralysis, by the Department of Public Assistance of Pennsylvania, and the Graduate School of Public Health of Pittsburgh among others.

Report from AMA Delegates: Dr. Appel, chairman of the delegates from the MSSP to the AMA Interim Meeting in Washington, D. C., December 6-9, presented an informative and very timely report (see page 156, February PMJ).

The Board by unanimous action instructed Dr. Donaldson to mail to county society secretaries the statements and usual triplicate receipts for the 1950 dues, incorporating in each, as enacted by our own 1949 House of Delegates, the amount of dues of the American Medical Association for 1950.

Election of Associate Members: Secretary Donaldson presented for election the nominees by component societies: Allegheny County, 3; Dauphin, Indiana, and Schuylkill, 1 each. By unanimous vote the named nominees were elected to associate membership.

Miscellaneous: Dr. Appel reported that in Lancaster County the School Health Advisory Committee of the State Department of Public Instruction had set up directives stemming from the School Health Act and giving standards of qualification for those who may ex-

amine school children by limiting performance of ear examinations to certified otologists only. There is only one such in Lancaster County, but there are other well qualified uncertified otologists. Further, Lancaster County does not have a rheumatic fever clinic because there is no certified cardiologist available. Dr. Palmer interviewed Dr. Dickey in the State Health Department, who thinks the situation in Lancaster County may be corrected next September. Dr. Appel requested the Board to support Dr. Palmer in an effort to have this directive changed promptly so that such qualifications may be determined at the local level and in many Pennsylvania counties permit more school examinations to become effective.

The Board voted unanimously that since the authoritative bodies of The Medical Society of the State of Pennsylvania have agreed that in addition to certified specialists those who are recognized by their county medical societies are also specialists they should be acceptable to the State's health services. Dr. Palmer promised to so advise the proper State authorities and to urge acceptance.

Dr. Appel stated that this policy of specifying professional services by Board diplomates only is not in the law. The offending directive stems from the Advisory Council to the Health Department.

Dr. Whitehill brought to the Board's attention some complaints on the absence of guards at the entrance to exhibit halls. During the Society's annual convention undesirable visitors occupy the space rented by exhibitors and waste their time in idle questions.

The Board authorized the convention manager to have an *effective guard system installed* at the 1950 convention.

Dr. Petry stated that the Hill-Burton Bill had been extended for an additional period of three years, and that the amount available has been increased to \$9,000,000, of which 33 $\frac{1}{3}$ per cent has been earmarked for other than general hospital beds.

Commission on Preventive Medicine and Public Health: Chairman Lucchesi reported on a *summary of Survey recommendations*. First was the large volume titled "Keystones of Public Health for Pennsylvania." Second, a Digest of this report was made by the Commonwealth Foundation. Before the "Keystones" report was released, it was decided that 1000 copies of the full report would be available. Third, since there has been so much interest, it has been decided to epitomize the Commonwealth Digest, which it is estimated will cost about 10 cents per copy.

The Board approved the publication of a brochure containing a summary of the recommendations appearing in the Survey report. Originally it was expected that the State Society would receive about 900 copies of the large volume; instead, 536 copies were received. There were requests for over 800. The State Society will need several hundred additional copies. For example, at the last House of Delegates session, it was recommended that all of the commissions and committees of the State Society that have an interest in this report be assigned the responsibility of going over it and making reports to our Board of Trustees; 143 copies would

be needed for State Society committees, plus 262 for the State Legislature, also 70 copies for organizations in the Pennsylvania Health Council.

Chairman Klump reminded the Board that many organizations should underwrite the cost of the copies they need and our society should purchase sufficient copies to supply our own committees. He said that Pennsylvania legislators should be interested in it because it contains six or eight references to needed legislation in which our Committee on Public Health Legislation will play a role so important that it should be directed to study the needed legislation.

Free discussion followed regarding the number actually needed by the MSSP.

By unanimous action the Board will purchase 300 copies of the complete Survey report at a price not to exceed \$2.15 per copy and the chairman of the Commission on Preventive Medicine and Public Health will ascertain the number of copies for which other organizations will subscribe.

Chairman Lucchesi obtained permission to call a commission meeting for January 8, the chairmen of all State Society committees and commissions concerned with the Survey to be invited, also the Secretary of Health and representatives of other interested groups.

Chairman Klump emphasized the need for important items to be considered, and it was the feeling of the Commission on Preventive Medicine and Public Health that the Committee on Public Health Legislation should be alerted to study important legislative items appearing throughout the Survey report, and also be prepared to discuss possible incidental legislation with the Society's various committees and commissions as they may meet from time to time, and to lay special emphasis on the two portions approved by the 1949 House of Delegates. (SECRETARY'S NOTE: See minutes of House of Delegates, pages 1889-90, December, 1949 PENNSYLVANIA MEDICAL JOURNAL.)

By unanimous action the report of the Commission on Preventive Medicine and Public Health was accepted.

It was unanimously decided that the next Board meetings be held Thursday, March 2, 1950, at 9 a.m., and Friday afternoon, March 3, following adjournment of the Secretaries-Editors Conference.

The meeting adjourned at 1:15 p.m.

GEORGE S. KLUMP, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since January 3. Figures in first column denote county society numbers; second column, State Society numbers.

Jan. 3	Luzerne (1949) 369	10756	\$15.00
5	Allegheny (1949) 1653	10757	15.00
9	Berks 1-50	18-67	1,150.00
	Bucks 1-21	68-88	483.00
	Clinton 1-12	89-100	276.00

Jan. 10	Northampton	1-38	101-138	\$874.00
	Northampton	225	139	23.00
11	Lawrence	1-9	140-148	207.00
	Bucks	22-34	149-161	299.00
	Juniata	1-4	162-165	92.00
	Warren	6-13	166-173	184.00
	Armstrong	1-15	174-188	345.00
	York	1-33	189-221	759.00
	Cumberland	1-9, 11-17	222-237	368.00
	Chester	1-40	238-277	920.00
	Berks	51-107	278-334	1,311.00
	Bucks	35-43	335-343	207.00
	Indiana	1-20	344-363	460.00
	Butler	1-18	364-381	414.00
	Clearfield (1949)	50	10758	15.00
	Delaware	1-13,		
		18-42, 44-105	382-481	2,300.00
	York	34-58	482-506	575.00
17	Clearfield	1-21	507-527	483.00
	Dauphin	1-92	528-619	2,116.00
	Columbia	1-13	620-632	299.00
18	York	59-70	633-644	276.00
	Juniata	5	645	23.00
	Northumberland	1-24	646-669	552.00
19	Westmoreland	1-13,		
		15-63	670-731	1,426.00
	Armstrong	16-24	732-740	207.00
	Luzerne	1-23	741-763	529.00
	Chester	41-50	764-773	230.00
20	Lackawanna	1-26	774-799	598.00
	Northampton	39-103	800-864	1,495.00
	Lycoming	4-5	865-866	46.00
	Chester	51-59	867-875	207.00
23	Mercer	1-20	876-895	460.00
	Butler	19-26	896-903	184.00
	Berks	108-132	904-928	575.00
	Delaware	106-137	929-960	736.00
	Bucks	44-51	961-968	184.00
	York	71-80	969-978	230.00
24	Jefferson	1-28	979-1006	644.00
	Lackawanna	27-33, 35-46	1007-1025	437.00
	Cumberland	18-23	1026-1031	138.00
	Warren	14-31	1032-1049	414.00
	Somerset	1	1050	23.00
	Lebanon	1-19	1051-1069	437.00
	Columbia	14-24	1070-1080	253.00
	Clinton	13-15	1081-1083	69.00
25	Montour	1-19	1084-1102	437.00
	Clearfield	22-30	1103-1111	207.00
	Franklin	1-56	1112-1167	1,288.00
26	Indiana	21-25	1168-1172	115.00
	Allegheny	1, 3-714	1173-1885	16,399.00
	Washington	1-56	1886-1941	1,288.00
27	Lebanon	20-39	1942-1959	414.00
28	Lackawanna	47-62	1960-1975	368.00
	McKean	1-14	1976-1989	322.00
30	Somerset	2-3	1990-1991	46.00
	Armstrong	25-29	1992-1996	115.00
	Butler	27-32	1997-2002	138.00
	Cumberland	24-27	2003-2006	92.00
	York	81-102	2007-2028	506.00
	Berks	133-144	2029-2040	276.00
	Luzerne	24-43	2041-2060	460.00

CHANGES IN MEMBERSHIP

New (78) and Reinstated (5) Members

ALLEGHENY COUNTY: B. Irene Armstrong, William R. Bailey, Robert F. Botkin, John E. Clever, James C. Fleming, Jr., Harry E. Hile, Jr., Sidney S. Kaufman, J. Allen McAfoos, Constantine Z. Moraitis, David Orringer, Harold Stangel, Donald W. Stechschulte, Stuart S. Stevenson, and John E. Weber, Pittsburgh; Michael F. Dimun, Carnegie; Stephen A. Hilton, McKeesport; William H. McCafferty, Coraopolis; G. Robert Senita, Wexford. (Reinstated) John L. Humphreys, Pittsburgh.

BUCKS COUNTY: Donald M. Feigley, Quakertown.

CAMBRIA COUNTY: Gerald C. Leary, Johnstown; James E. Miller, Windber.

CHESTER COUNTY: Clifton M. Durning, Kennett Square; Moe Price Margolies, Scarsdale, N. Y.

CLEARFIELD COUNTY: (R) H. H. Lewis, Jr., Pittsburgh.

DAUPHIN COUNTY: Sumner H. Friedman, Harrisburg; Thomas L. Leaman, Hershey.

DELAWARE COUNTY: Daniel J. Hilferty, Jr., Swarthmore.

FRANKLIN COUNTY: Jared S. Brown, Mercersburg; Grover C. Kirk, Chambersburg; John W. Smythe, South Mountain.

LACKAWANNA COUNTY: Victor J. Covalsky and Louis R. Murphy, Scranton; Stephen R. Jewett, Clarks Summit; Joseph B. Krisanda, Jessup.

LEBANON COUNTY: Patrick J. Frank and James M. Keiter, Lebanon; William W. Huntress, Annville.

LUZERNE COUNTY: Michael Bucan and Anthony E. Chmielewski, Wilkes-Barre; Stanley S. Tanz, Hazleton; Anthony G. Stish, Jr., W. Hazleton. (R) Elizabeth O. Hayes, Atlantic Beach, N. C.

McKEAN COUNTY: Matthew Rotstein, Bradford.

MONTOUR COUNTY: Robert L. Gatski, Thomas K. Hepler, and Theodore V. Schepeler, Danville.

NORTHAMPTON COUNTY: Thomas D. Duane, Floyd E. Shaffer, and Lawrence T. Smyth, Bethlehem; Charles W. Iobst, Chester.

NORTHUMBERLAND COUNTY: Elwood E. Fisher, Middleburg; Joseph L. Nosal, Sunbury.

PHILADELPHIA COUNTY: Barkley Beidleman, Matthew S. Cappuccio, John J. Curtin, Margaret E. Densmore, Kalman Faber, Sidney Friedman, William A. Haeberle, Joseph A. Jelen, Herbert H. Lakoff, W. Munro Leslie, Donald J. McDonald, Richard D. Moore, Alfons J. Muller, Robert A. Murphy, Gaylord W. Ojers, Robert L. Scanlan, John G. Shinn, Robert J. Snyder, Herbert M. Stauffer, E. Earl Trout, and Donald N. Tschan, Philadelphia; Paul T. Makler and Harold S. Medoff, Drexel Hill. (R) E. Fremont Milliken and Lorenzo F. Milliken, Drexel Hill.

WAYNE-PIKE COUNTY: Henry C. Dirlam, Honesdale.

YORK COUNTY: Dean S. Hoover, J. Albert Jackson, and Charles P. Lamon, Jr., York.

Resignations (18), Transfers (12), Deaths (12)

ALLEGHENY: *Resignations*—James F. Culleton, Sewickley; John W. Prout, Biloxi, Miss. *Deaths*—Richard A. Caldwell, Aspinwall (Hahn. Med. Coll. '38), December 22, aged 37; Howard S. Reiter, McKeesport (Univ. Pgh. '20), January 13, aged 54; Wilford L. Thunhurst, Wilkinsburg (Univ. Pgh. '09), January 5, aged 62.

BUCKS: *Transfer*—Octavius Capriotti, Souderton, from Montgomery County Society. *Death*—John C. Kachline, Quakertown (Med.-Chi. Coll. '01), December, 1949, aged 75.

BUTLER: *Transfer*—Franklin W. Rudolph, Butler, from Allegheny County Society. *Resignations*—Robert Armen, Paul Kassandra, and Otto Schaefer, Butler.

CLEARFIELD: *Death*—Austin C. Lynn, Philipsburg (Med.-Chi. Coll. '11), December 27, aged 62.

DELAWARE: *Transfers*—Burton L. Williams, Philadelphia, Herman D. Staples and John F. Ambrose, Upper Darby, from Philadelphia County Society. *Resignations*—Richard M. Irwin, Avondale; Emilie C. Schirmer, Havertown. *Death*—Florence E. Kraker, Media (Woman's Med. Coll. '05), January 3, aged 72.

FRANKLIN: *Transfer*—James B. French, Las Vegas, Nev., to Nevada State Medical Society.

LEBANON: *Transfers*—Matthew J. Oliva, Philadelphia, to Camden (N. J.) Medical Society; Herbert H. Kerr, R. D. 2, Jonestown, from Lancaster County Society.

LUZERNE: *Resignation*—Olive T. Baskett, Bellevue, Wash.

MONROE: *Transfers*—James D. Maxwell, Stroudsburg, from Philadelphia County Society; George J. Heid, Bushkill, from Mifflin County Society.

MONTGOMERY: *Resignations*—Percival Nicholson, Ardmore; Miles D. Garber, Jr., Norristown. *Death*—Joseph A. Fitzmaurice, Bala-Cynwyd (Columbia Univ. '26), December 31, aged 52.

MONTGOMERY: *Resignation*—Harry W. McCurdy, Battle Creek, Mich.

NORTHAMPTON: *Transfer*—James T. Moy, Wichita, Kansas, to Sedgwick County (Kan.) Medical Society.

PHILADELPHIA: *Transfer*—Theodore S. Stashak, Oakland, Calif., to Sonoma (Calif.) Medical Society. *Resignations*—Leo B. Freeman, Thomas Kerr, Jr., Everett A. Tyler, and Edward J. Ward, Philadelphia. *Deaths*—Abraham J. Cohen, Philadelphia (Jeff. Med. Coll. '03), December 30, aged 70; Edwin A. Heller, Philadelphia (Univ. Pa. '95), December 24, aged 77; Vincent Marcucci, Philadelphia (Med. Chi. Coll. '15), January 8, aged 56.

POTTER: *Resignations*—Ruth P. Mosch, Coudersport; William J. McGee, Keokee, Va.

WARREN: *Death*—Edwin Gail Hamilton, Warren (Univ. Pa. '19), January 23, aged 57.

WASHINGTON: *Transfer*—Victor J. Wicks, Burgettstown, from Indiana County Society. *Resignation*—George S. Wallace, Marianna. *Death*—Wilbur J. Hawkins, Jr., Fredericktown (Jeff. Med. Coll. '33), January 23, aged 44.

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The following requests were filled during the month of January:

Acute pancreatitis	Male climacteric
Paroxysmal tachycardia	Hay fever immunity
Convulsions	Dust pollen therapy
Plastic surgery	Headache
Spasticity in children	Nasal secretions
Aberrant thyroid	Treatment of obesity
School health	Pancreatitis
New drugs	Potassium deficiency
Sex education	Cancer of the breast
Adaptation syndrome (2)	Headaches of ocular origin
Role of emotion in disease	Bursitis
Vagotomy	Low back pain
Puerperium	Erythema nodosum
Teaching sex to children	Arachnidism
Mongolism	Collagen disease
Heart diseases	Melanomas of the eye
Sterility in women	Acute porphyria
Gonorrhea in the female	Health insurance
Ectopic pregnancy	Medical benevolence fund
Fibroids of the uterus	Child psychology
Anthraco-silicosis (2)	Pityriasis rubra
Cancer	Erythroderma
Gout	Geriatrics
Duodenal ulcers	Industrial health
Paget's disease	Growth of children
Euthanasia (4)	Vascular diseases
Heart disease in industry	Heart examination
Abnormalities of ribs	Circulatory system
Leukoplakia buccalis	Growth of bones
Ulcerative colitis (2)	Hygiene

Use of veratrum viride in eclampsia and hypertension
 Venous thrombosis and pulmonary embolism
 Therapy of the Rh pregnant woman
 Treatment of anemia in childhood
 Deaths of physicians due to cancer
 Surgery of lacrimal sac (2)
 Successful collection methods
 Intracranial hemorrhage in the newborn
 Pelvic tuberculosis in the female
 Value of x-ray in obstetrics
 Hydrogen ion concentration
 Treatment of rheumatoid arthritis
 Dietetic measures in urinary calculi
 Postoperative management of ileostomy
 Treatment and diagnosis of allergy
 Malpractice in Pennsylvania
 Medical Service Association
 Thyroid gland and its relation to growth
 Treatment of pulmonary tuberculosis (2)
 Use of para-aminosalicylic acid in pulmonary tuberculosis
 Catatonic type of schizophrenia

Use of nitrogen mustard in Hodgkin's disease
 Whipple operation for cancer of head of the pancreas
 Diagnosis and treatment of parathyroid diseases
 Medical schools in the United States
 Antihistaminic drugs in endogenous uveal disease
 Chemotherapy in surgical infections
 Effects of the cold wave process
 Antihistaminics and allergy
 Medical history of Pennsylvania
 Psychosomatic medicine (2)
 Trauma and diabetes mellitus
 Treatment of multiple sclerosis
 Effects of tobacco in the body
 Technique for vaginal smears
 Removal of superfluous hair
 Dermatologic problems in geriatrics
 Goldblatt and experimental hypertension
 Control of disease by sterilization
 Pseudofractures in osteomalacia
 Cataract extraction (2)
 Cholesterol metabolism in health and disease
 Treatment of gastro-enterocolitis

ALLERGISTS TO MEET

The Pennsylvania Allergy Association will meet at the Bedford Springs Hotel, Bedford, Wednesday and Thursday, May 10 and 11.

The meeting will open with a Board of Regents session Wednesday evening. The scientific program will begin at 10 o'clock Thursday morning following welcoming addresses by Dr. Harry A. Shimer, president of the Bedford County Medical Society, and Dr. Leard R. Altamus, trustee and councilor, Eleventh Councilor District of The Medical Society of the State of Pennsylvania. Dr. Hyman A. Slesinger, Windber, will preside over the morning scientific session.

The following papers will be presented at the morning session: "Explosive Reactions in Dermatologic Allergy," Dr. Joseph Ricchiuti, Jr., Pottsville; "The Botany of Allergy," Dr. Edward Claus, Pittsburgh; "Gastro-intestinal Manifestations of Allergy During Childhood," Dr. Joseph Fries, Brooklyn, N. Y.; "X-Ray and Its Importance in the Diagnosis and Treatment of Allergic Disorders," Dr. Walter W. Werley, Reading.

The afternoon session under the chairmanship of Dr. Benjamin H. Hamner, Williamsport, will be opened with a paper entitled "Drugs in Allergic Therapy" by Dr. Stephen D. Locky, Lancaster. This is to be followed by a panel discussion on "The Present Status of Bacterial Allergy." Participants will be: Drs. Richard A. Kern, Philadelphia; Russell C. Grove, New York; John E. Gregory, Philadelphia; and Archibald R. Judd, Hamburg.

A banquet will conclude the meeting.

MAKING THE PATIENT FIT THE PRESCRIPTION

"Simplified prescription writing" has now been inaugurated in the British Health Service. Instead of tailor-making a prescription to fit the need of the patient, the doctor will simply select a prescription from an official government formulary designating it by short title. The formulary contains about 600 prescriptions and, says the British Health Ministry, "it will be unnecessary for doctors to prescribe outside the scope of the *Formulary*." *Journal of the Medical Society of New Jersey*.

AMERICAN BOARD OF OPHTHALMOLOGY

Candidates for the certificate of the American Board of Ophthalmology are accepted for examination on the evidence of a written qualifying test. These tests are held annually in various parts of the United States.

Applications are now being accepted for the 1951 written test, and will be considered in order of their receipt until the quota is filled. They should be sent to the Executive Office, 56 Ivie Road, Cape Cottage, Maine.

Practical examinations for acceptable candidates in 1950 will be held in Boston from May 22 to 26, and in Chicago from October 2 to 6.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

EVIDENCE that the practice of x-raying the chests of all patients admitted to general hospitals is an efficient means of discovering unsuspected cases of tuberculosis continues to accumulate. The procedure not only aids the physician and gives the patient the benefit of early diagnosis; it also protects hospital personnel and advances the control of tuberculosis in the community.

ROUTINE CHEST PHOTOROENTGENOGRAPHY IN BARONESS ERLANGER HOSPITAL, CHATTANOOGA, TENNESSEE

Early in 1946, Baroness Erlanger Hospital in Chattanooga accepted as a permanent loan from the State Department of Public Health in Tennessee photoroentgen equipment for the purpose of doing routine chest roentgenograms on all persons admitted to the hospital. At that time the Chattanooga-Hamilton County Health Department was operating a stationary photofluorograph for clinic use and a mobile unit for the roentgenographic examination of persons in industry, schools, and the community. The equipment placed at the general hospital, therefore, rounded out the case-finding program and made routine chest roentgenograms for the discovery of cases of tuberculosis available to another population group.

Procedure

The stationary 35 mm. photofluorograph in the health department clinic is used to examine contacts of known cases of tuberculosis, food-handlers, teachers, barbers, and beauty operators, persons applying for employment in certain industries, patients referred by physicians, persons desiring roentgenograms because of symptoms or for some other reason, a few students referred from schools, and a miscellaneous group. The individuals included in this survey are designated the Health Department Clinic Group.

The groups surveyed by the mobile unit are classified as community, industrial, or school.

The community group includes adults living in residential areas of Chattanooga and Hamilton County. The industrial group consists primarily of workers employed in manufacturing plants. In the school group are students 15 years of age or over. The three subgroups are combined as the Mobile Unit Group.

The plan to obtain chest roentgenograms routinely on all persons admitted to the Baroness Erlanger Hospital was not attempted at first. Employees and any nonpaying patients (primarily indigent), a few private patients, and persons referred from the emergency room were included in the first survey. This group of persons is designated the Hospital Group.

Analyses of the clinic and mobile unit groups are for the year 1946, and that for the hospital group is for the period April 1 through December 31, 1947. This report seems indicated because of the relatively high percentage of pulmonary tuberculosis discovered in the group examined roentgenographically on admission to the hospital.

RESULTS OF PHOTOROENTGEN EXAMINATIONS FROM THREE TYPES OF SURVEYS, CHATTANOOGA-HAMILTON COUNTY 1946-1947

Group	Number		
	Examined	Cases	Per Cent
Health department clinic, 1946	13,966	383	2.7
Mobile unit, 1946	14,293	290	2.0
Hospital unit, 1947	5,187	193	3.7
All surveys	33,446	866	2.6

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RESEARCH IN THE SERVICE OF MEDICINE

Discussion

The highest percentage of cases of tuberculosis (3.7) was found in the hospital group, but this should not minimize the finding that 2.0 and 2.7 per cent of persons examined in the mobile unit and clinic groups had tuberculosis.* Surveys such as this have proved their value repeatedly during recent years. Routine roentgenographic examination of hospital admissions, however, has not received the attention it merits. The risk to the medical student, nurse, or hospital employee of cases of unrecognized tuberculosis in the hospital population has been noted, but all too often the exceptional opportunity for tuberculosis case finding provided by the hospital population has been overlooked. Unrecognized tuberculosis among hospital employees and patients imposes a responsibility upon the hospital that is difficult to ignore.

It is interesting to compare the make-up of the hospital survey group and the health department clinic group. In no subgroup of the mobile unit group has tuberculosis been found to be higher than 2.7 per cent. There is no outpatient tuberculosis clinic at Baroness Erlanger Hospital, and patients are admitted for hospital and clinic services for complaints other than tuberculosis. Except for diabetes, tumor, and venereal disease clinics (which might be expected to have considerable unrecognized tuberculosis), there was no special subgroup that contributed to the high percentage (3.7) of persons found with tuberculosis in the hospital population. On the other hand, the health department clinic examined such subgroups as contacts (5.5 per cent with tuberculosis), barbers and beauty operators (7.7 per cent), and patients referred by physicians

(9.3 per cent), in all of whom cases of tuberculosis are discovered frequently. This makes it more apparent that routine chest roentgenographic examinations of patients admitted to general hospitals should be seriously considered as a responsibility of the hospital and its contribution to the tuberculosis control program.

The success of any tuberculosis case-finding program depends upon the finding of early cases of the disease. In the clinic and mobile unit groups 65 to 70 per cent of the lesions discovered were minimal in extent. It was surprising to find that among the hospital population examined, 92 per cent of the lesions discovered were classified as minimal. In only 7 per cent of the patients were the lesions moderately advanced, and in only one per cent were the lesions far advanced. Of the total number of cases of tuberculosis discovered, 21 per cent were active lesions of minimal extent. The amount of tuberculosis found among young adults was high in the hospital group.

With the advent of photofluorography it was expected that many general hospitals would take advantage of this economical technique and adopt chest roentgenograms as a routine procedure. This has not occurred. While mass radiographic procedures are taken for granted in other population groups, there still seems to be some reluctance to use routine chest roentgenography on general hospital patients. This reluctance is difficult to understand. It appears that this one population group has been handed to those seeking out unsuspected cases of tuberculosis in the community "on a silver platter."

Routine Chest Photoroentgenography in Baroness Erlanger Hospital, Chattanooga, Tennessee, Paul M. Golley, M.D., The American Review of Tuberculosis, September, 1949.

* EDITOR'S NOTE: These percentages refer to reinfection-type tuberculosis, but it should be noted that this does not mean that all cases were clinically significant.

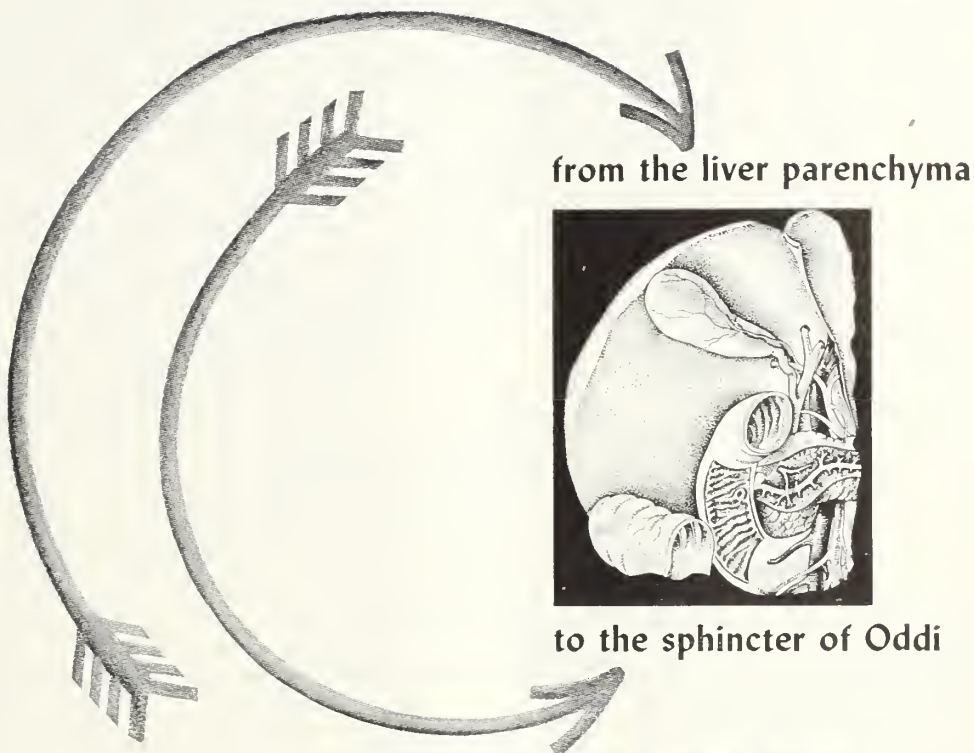
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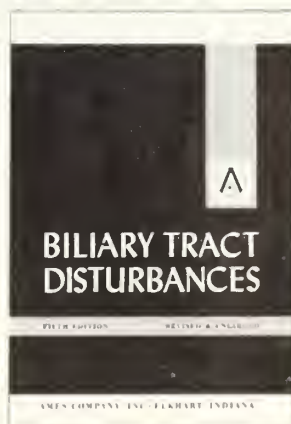
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 3. How much floor space will you require?
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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street, Indiana

A PRESIDENT'S EYE-VIEW OF THE COUNTIES



It is now January and the county visits have been completed. Your president breathes a sigh of relief, for the weatherman has been most considerate. There have been only two rainy days during the thousands of miles of travel since September,

and no ice or snow. During the week spent in the Pittsburgh area high temperatures produced a June-in-January atmosphere.

January 9—BERKS county, the birthplace of the Woman's Auxiliary, welcomed your president at a luncheon meeting in Reading. Presiding at the table was Mrs. Clair G. Spangler, Berks County president, and guests of honor were Mrs. Wellington D. Griesemer, Mrs. Leon C. Darrah, and Mrs. Paul C. Craig, all past state presidents of whom Berks County and the State can be justly proud. The district councilor, Mrs. Elmer H. Bausch, and the first vice-president, Mrs. J. Frederic Dreyer, from Lehigh County, Mrs. Edward H. Bedrossian, state corresponding secretary, and Mrs. Edgar S. Buyers, honorary member of the State Auxiliary, were present. Berks auxiliary had many new members to introduce and a fine report to give on their study groups. A newsletter sent to all members of this auxiliary by their president and fine publicity given them in the bulletin of their medical society show that they are recognized for the work they do.

January 10 — PHILADELPHIA county auxiliary had nearly 200 members present at a luncheon in the Philadelphia County Medical Society Building. The guest speaker was Ivan H. Peterman, well-known columnist for *The Philadelphia Inquirer* and an on-the-spot reporter for news during the last war. It was enlightening to hear his views on today's world problems.

At the board meeting preceding the regular

meeting, your president received a glimpse of this large auxiliary's work. Especially worthy of notice is the work done by this county in support of benevolence. The Christmas bazaar this year brought in over \$1,800, all of which will go toward helping needy Philadelphia County physicians and their families. Philadelphia County receives no aid from the State Society benevolence fund, for it takes care of its own. However, these women always see that a generous contribution is made to the state fund for use in other counties.

January 23—Your president, accompanied by Mrs. Hubert J. Goodrich, Tenth District councilor, visited BEAVER county auxiliary in Rochester. Approximately forty members attended, and the president, Mrs. Charles L. McMillen, presided. Work reported by various chairmen indicated that Beaver County is very alert. Splendid cooperation with the medical society has put the National Education Campaign in high gear. Members reported almost 100 per cent on sending in the twenty names for the Personal Contact Campaign, as guided by Mrs. Maurice V. Ross, president-elect.

January 24—ALLEGHENY county auxiliary celebrated its twenty-fifth birthday at the Hotel Schenley, Pittsburgh. Its executive board met for luncheon preceding the program with your president and president-elect as guests of honor. The birthday party began with a reenactment of the first meeting of that auxiliary in 1924 when Dr. Walter F. Donaldson, secretary of the State Medical Society, advised the women at their organization meeting and wished them years of successful service. Mrs. James I. Johnston, the first president, responded to Dr. Donaldson's kindly and encouraging words and promised cooperation and service from this then new auxiliary. It is significant to note that the first activity of this auxiliary was to assist the medical society in securing the passage of needed health legislation.

Mrs. David B. Ludwig, historian, continued

the program by introducing the past county presidents in poetry and telling of administrative achievements during the term of each in office. A fashion show, depicting gowns and hat styles of the 1924-49 period and modeled by members of the auxiliary under the direction of Mrs. Walter E. Starz, brought to mind a true-to-life picture during the historical reading.

Each past president was presented with a beautiful hand-made gold and silver pin designed by Miss Olivia Koenig, who had so artfully fashioned the State Auxiliary president's pin. A pleasant social hour followed with real party refreshments served by the hostesses. Guests of the afternoon had come from the neighboring counties to help in celebrating the birthday. The surprise of the day was the presence of Mrs. Edgar S. Buyers, Norristown, our first state honorary member, who had traveled all the way across the State to congratulate the honor guests, the past presidents of Allegheny County.

In the evening your president, accompanied by Mrs. Hamman and Mrs. Buyers, met with members of the INDIANA auxiliary in the nurses' home of the local hospital. In the absence of the president, Mrs. Frederick J. Kellam, the vice-president, Mrs. H. Curtis Long, presided. An interested guest was Miss Adeline Hawxhurst, superintendent of the Indiana Hospital, who graciously welcomed the auxiliary members and conducted a tour of the nurses' home. Miss Hawxhurst was most appreciative of the work of the auxiliary and offered to be of assistance in the public relations program, especially in the distribution of literature dealing with voluntary health insurance plans to patients and nurses.

With this visit to Indiana, the official schedule has been concluded and your president now turns to plans for the annual conference and convention.

The guest book which she had asked all of you to sign as she visited you on her travels is now filled and contains almost 1400 names. In several of the larger meetings time did not allow for everyone to sign her name, but the record of attendance at these meetings has been quite a tribute to the women who make up the membership of this Auxiliary to The Medical Society of the State of Pennsylvania. The record of service which these women give in the per-

formance of auxiliary duties is one which they can point to with pride.

(MRS. DRURY) ELIZABETH M. HINTON,
President.

A SUGGESTION FOR PUBLIC RELATIONS

The Profession's Part in Annual Community Fund Campaigns

At the September, 1949 convention of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, the need for better public relations and the building of good will were stressed. One way this can be done is being shown by the Woman's Auxiliary to the Lehigh County Medical Society.

Acting upon the suggestion of some of the doctors in 1948, the women formed a committee to solicit members of the medical profession during the Red Feather Community Fund Drive. This relieved the doctors of the time-consuming job of contacting their equally busy colleagues. With their close understanding of doctors' hours and problems, and because of their own more flexible schedules, the women were able to make contacts at hours convenient to the physicians, many of whom have expressed appreciation.

Plans were organized with the assistance of the chairman of the Professional Division (all professions) and the executive secretary of the Community Chest at the home of the auxiliary president who was chairman of the Physicians' Group. At that time the functions of the thirty agencies within its scope were explained by movies and discussion. (Incidentally, some of the wives met each other for the first time that evening.)

It was most gratifying to the auxiliary members to discover anew the extent to which the doctors believed in the good old American custom of helping the other fellow over and above what they had contributed through free medical services in their everyday routines. They believe that it unites the people for the good of the whole community and have shown that they appreciate the economy of administration not only in dollars but in time and leadership.

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scriptions and in 1949 forty-three increases were noted, some of which had been increased in 1948. These figures represent the donations of the profession in Allentown itself, numbering 138. Doctors of the boroughs and townships of Lehigh County contributed directly to the fund raised by their local divisions as a part of the over-all campaign.

Medical men who have been in practice less than three years are not solicited and are not included in the above figures. Letters were sent to them by the Community Chest stating that they realized some would be financially burdened. If they wished to contribute, they were requested to contact the Physicians' Group chairman. Several responded generously. They appreciate this consideration, since most would like to assume their community responsibilities but cannot do so at once.

The close cooperation of the medical men, their wives, and the Community Chest is proof to the public that all want to remain free to properly care for their own. Why don't you try it?

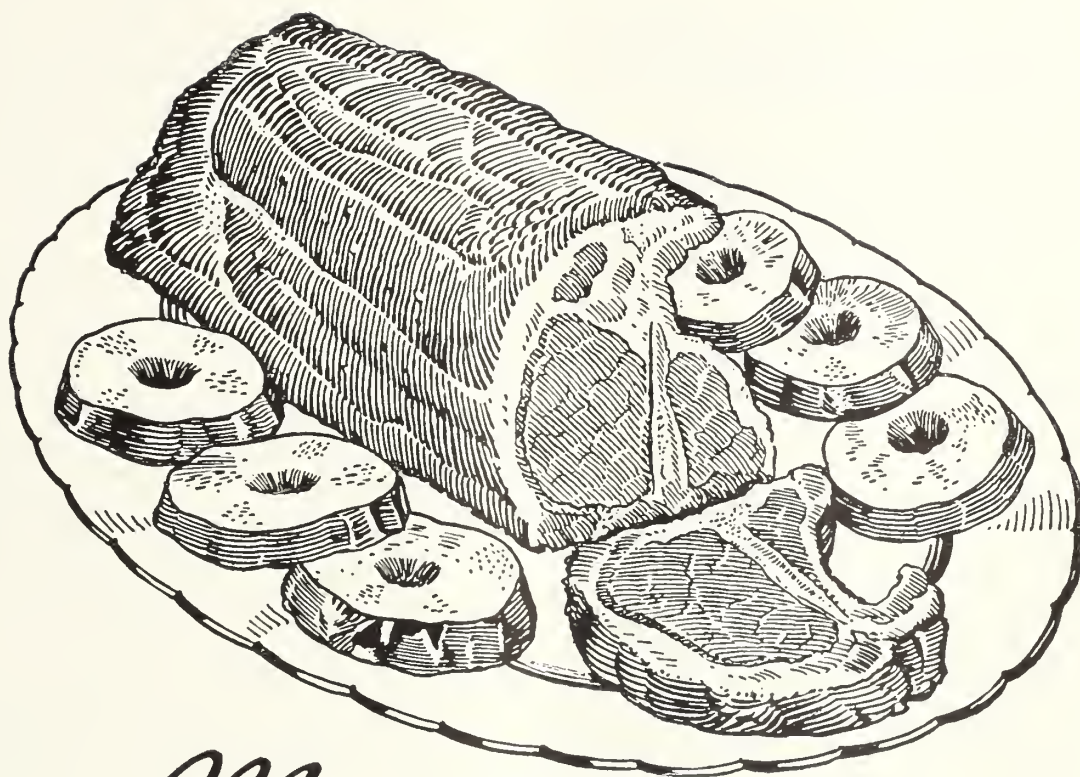
(MRS. J. FREDERIC) ALMEDA J. DREYER,
Lehigh County.

COMMUNITY SERVICE

No doubt many county auxiliaries and the individual members have participated recently in activities that have resulted in good public relations, although the motivating idea was community service alone.

On page 59 of the January JOURNAL there was pictured an exhibit of "The Doctor" which was featured in the fall fund-raising campaign of the Wyoming Valley Community Chest. The full story of this exhibit was not told in the caption of the photograph; however, it should be related to show the potential possibilities for community service in other localities.

A member of the Luzerne County Auxiliary, Mrs. Charles F. Netzel, of Plymouth, conceived and executed the idea. Mrs. Netzel enlisted the cooperation of the Little Theatre Group of Wilkes-Barre to construct the set. The local Salvation Army graciously furnished trucks to transport the set and furnishings. Several physicians not only took part in the portrayal but also defrayed the cost of the display.



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (Apr. 2,) 1949

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This effort resulted not only in a \$500 prize, which was donated to the Community Chest, but also in excellent publicity for the medical profession.

WHEELS TURNING

The wheels of auxiliary progress, as reported in the January PENNSYLVANIA MEDICAL JOURNAL by Mrs. Rufus M. Bierly and in the February issue by our president, Mrs. Drury Hinton, are constantly going forward as shown by news received from twelve counties.

BERKS—The October meeting featuring the film, "Human Growth," with commentary by Dr. William Finzer, was open to the public. In November a dinner-dance was held at the Berkshire Country Club. At the regular November meeting, Mr. Merrill Durdan from the Y.M.C.A. discussed "Community Recreation." "Christmas Music of Many Lands" was presented by Mrs. Paul Breedy on December 12. The auxiliary is gratified with the number of women who have shown serious interest in the legislative study meetings, under the direction of Mrs. Herman F. Kotzen, legislation chairman. The Berks County *Bulletin* has been utilized this year to feature various auxiliary projects and the A.M.A. National Education Campaign.

CAMBRIDG—At the January meeting, Miss Margaret Fritz of the American Cancer Society outlined the need

for volunteers to help in the cancer education program and the need for supplies at the center. Several members volunteered their services to the Cancer Society and bandages and shirts will be collected. Information has been gathered concerning registration of the doctors and their families. Medical samples have been collected and sent to New York for distribution in Europe.

DAUPHIN—On October 4, delegates to the state convention, Mrs. J. Collier Bolton, Mrs. Ross K. Childerhose, Mrs. John V. Foster, Mrs. Kermit L. Leitner, Mrs. Donald E. Morrison, and Mrs. A. Harvey Simmons, gave their reports, and Mr. Carl Donley, district manager of the Medical Service Association of Pennsylvania, spoke on the Blue Shield Plan.

Members of the auxiliary were active in stimulating public interest for the Harrisburg Town Meeting of the Air, November 1. The subject of debate was "Socialized Medicine." Mr. Michael Johnson, head of the Ladies' Garment Workers Union, argued in favor of the topic, and Robert Denison, M.D., and Leo E. Brown, executive assistant of the Committee on Public Relations, MSSP, presented the negative side.

The auxiliary joined the medical society at a dinner meeting, December 6, at the Harrisburg Country Club. Following dinner, the group went to the Harrisburg Academy of Medicine, at which time Congressman John C. Kunkel spoke on "What Is Going on in Washington."

DELAWARE—A Christmas party was held on December 8 at the home of Mrs. S. M. Criscom, the mother of Mrs. John H. Shackleton, Jr., in West

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Chester. Songs were sung by Mrs. Rocco I. de-Prophetis, and Mrs. Ernest L. Noone gave two humorous and whimsical readings. A record of Charles Laughton's reading of the Christmas story from the Bible was played, and group singing concluded the program. Tea was then served.

INDIANA—A Christmas party with the medical society was held in December at the Indiana Country Club. Gifts were brought and then given to the Indiana County Child Welfare Service for distribution. The auxiliary also gave 100 packages, 50 containing candy and 50 containing gifts, to Indiana County patients at the Torrance State Hospital, for distribution on Christmas. Seven new members were welcomed this year: Mrs. William G. Evans, Dixonville; Mrs. Thomas Miles Hadden, Saltsburg; Mrs. Kenneth H. Sayers, Clymer; Mrs. George W. Hanna, Homer City; and from Indiana, Mrs. William H. Eastment, Mrs. Harold L. Edison, and Mrs. Forrest Smith.

JEFFERSON—At a meeting in Brookville on November 1, Jefferson reorganized, with Mrs. Howard H. Hamman and Mrs. Drury Hinton as guests. Their record in legislative activities shows how busy they have been. Mrs. George W. Means had 1800 letters mimeographed which have been sent by individuals to their congressmen, requesting them to vote against all legislation for socialized medicine. They have been responsible for ten organizations going on record as opposing socialized medicine.

LANCASTER—This group can be proud of the girl who received the \$100 scholarship last spring; the directress of nurses at the Lancaster General Hospital states that this girl is making grades of over ninety in almost all of her subjects. This year, to date, the committee has received two applications for the scholarship to be awarded this spring.

In Lancaster the Heart Seal Drive is sponsored by the American Legion in February. The medical auxiliary has assumed full responsibility for the opening and sorting of envelopes and the counting of money which is returned to headquarters for this drive. Part of the proceeds will help to support the new building for the treatment and convalescence of rheumatic children. This building is called Heart Haven and is to be dedicated during Heart Week.

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LEHIGH—The annual Christmas program was held December 13 at the Woman's Club, Allentown. During a brief business session, donations were made as follows: \$25 to the Girls' Haven and \$5 to the Lehigh County Tuberculosis Society. A French legend, "The Worker in Sandalwood," was read by Mrs. Donald W. Hafl, program chairman. During the reading a trio comprised of Mrs. Ray W. Pickel, music chairman, Mrs. Harry S. Good, and Mrs. Robert R. Muschlitz sang carols. The group joined in singing several Christmas songs. The program was concluded with "The Coventry Carol," arranged by Fred Waring and sung by the trio.

MIFFLIN—Miss Suzanne Treadwell of the Committee on Public Relations, MSSP, spoke on the program of national compulsory health insurance at the December meeting held in Green Gables Hotel, Lewis-town. Two new members were welcomed into the auxiliary—Mrs. Michael DeVita and Mrs. Andrew B. Steele.

NORTHAMPTON — The annual Christmas luncheon was held at the Hotel Bethlehem. Gifts were exchanged. Mrs. J. R. Fuehrer, Coopersburg, gave several Christmas readings, and Mrs. John A. Fraun-felder, Nazareth, accompanied carol singing. Mrs.

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Henry K. Heller, Bethlehem, was received as a new member.

Six new members were accepted in January—Mrs. Stephen Wetmore, Mrs. George Barrett, Mrs. Willis E. Manges, Mrs. George Steward, Mrs. Newton W. Larkum, and Mrs. Joseph T. Urban, all of Easton.

PHILADELPHIA—The annual Christmas bazaar was held December 6, from 10 a.m. to 5 p.m., in the auditorium of the County Medical Society Building. Prizes for the most artistic booths were awarded as follows: first prize, house furnishings booth, Mrs. William Bates, chairman; second prize, toy booth, Mrs. Earl A. Daugherty, chairman; and third prize, cakes, candies, and cookies booth, Mrs. Elliott F. McGuire. Luncheon was served in the basement grill. During the afternoon there was a short "carol sing" by the Bala-Cynwyd Junior High School choir. The bazaar was most successful financially, the proceeds to date being more than \$1,800.

The auxiliary voted a gift of \$625 to the Philadelphia Aid Association, \$125 of which was to be used for Christmas baskets. A token contribution was made to the Community Chest Drive.

On January 10 a luncheon was given in honor of the new members of the organization. Guest speakers were Mrs. Drury Hinton, state president, who talked on auxiliary work and activities, and Mr. Ivan H. Peterman, former sports writer and war correspondent, and now columnist on world affairs. Other guests introduced by Mrs. William A. Shannon, president, were Henry B. Kobler, M.D., president of the Philadelphia County Medical Society, and Mrs. Edward H. Bedrosian, State Auxiliary corresponding secretary.

WARREN—A Christmas party was held on December 15 at the Woman's Club, Warren, at which time members of the medical society were guests. The January meeting was held at the Warren General Hospital in the sewing room. This was definitely a work session and much was accomplished at the "sewing bee."

The wheels of progress turn on and on. Will you report the progress of *your* auxiliary to share with others?

MAKING HEALTH VISIBLE

The Medical Society of the State of Pennsylvania maintains a library of 16 mm. sound films on health subjects suitable for lay audiences which are available, on loan, to county medical societies, individual physicians, hospitals, service and women's clubs, schools, and other groups. There is no charge for these films other than the cost of return postage and insurance. Requests for films should be addressed to the Committee on Public Relations, The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa. Catalogs will be sent on request.

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GYNECOLOGY—Intensive Course, Two Weeks, starting March 20, April 17. Vaginal Approach to Pelvic Surgery, One Week, starting April 3.

OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31. Personal Course in Diagnosis and Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Electrocardiography and Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastro-enterology, Two Weeks, starting May 15. Liver and Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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Eyes for Tomorrow

Board of Directors, York Blind Center
Riverside Parent-Teacher Association, Harrisburg

Feeling of Rejection

Parent-Teacher Association, Halifax
East Pennsboro Parent-Teacher Association, Enola
Tuberculosis Sanatorium, Cresson
Steven's Parent-Teacher Association, Altoona
Forney School Parent-Teacher Association, Harrisburg

First Aid

Tuberculosis Sanatorium, Cresson

Human Growth

Ontelaunce Parent-Teacher Association, Leesport
Seventh and eighth grade girls, Hygienic School, Steelton
Glenwood Health Club, Harrisburg

Human Heart

Twin Borough Woman's Club, Mifflintown
Business and Professional Woman's Club, Altoona
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New Frontiers of Medicine

Business and Professional Woman's Club, Altoona
Emporium High School

One Against the World

School health groups, Dalton
M. Boyd Brandon, M.D., Reynoldsville

Seventh Column

Twin Borough Woman's Club, Mifflintown

ELECTROMYOGRAPHY IN ORTHOPEDICS

(By ARTHUR L. WATKINS, M.D., Boston, Mass.,
J. Bone & Joint Surg., October, 1949)

The orthopedic surgeon is regularly confronted with the problem of evaluating disorders of neuromuscular function. Although locomotion, strength, and skill can be tested fairly adequately for clinical purposes without elaborate apparatus, there are many cases in which diagnosis and prognosis can be ascertained with greater accuracy if muscular activity is analyzed in a more detailed manner. Electromyography has now been developed to a point where conclusions can be drawn as to its usefulness to the orthopedic surgeon in the better understanding of some of the complexities of neuromuscular disease.

Considerable interest exists as to the nature of muscle hyperirritability or "spasm" in acute and convalescent poliomyelitis. The clinical features are well known, but for their explanation investigators have turned to the electromyographic laboratory. Numerous reports from widely separated clinics have indicated the presence, in patients with acute poliomyelitis, of abnormal electrical activity in muscles at rest whether they have normal strength or are weakened. The completely paralyzed muscles, on the other hand, are electrically silent, with exceptions to be noted later. Change in position or passive stretching has been found to produce strong discharges from the muscles in spasm, corresponding to the clinical findings of pain and tenderness. This type of electromyogram resembles that recorded from mus-

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* *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245, *N. Y. State Journ. Med.*, Vol. 35, 6-1-25, No. 11, 590-592; *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154, *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

cles splinting a painful joint, secondary to fracture. We cannot say, however, whether or not the mechanism is the same or even similar, as the electromyogram gives information only as to the amount and character of peripheral activity. What is occurring in the central nervous system must as yet be left to conjecture.

Electromyography has demonstrated a further type of neuromuscular disorder in patients with poliomyelitis. This is the co-contraction of muscles of antagonistic function during attempts at voluntary motion. This is a type of incoordination or substitution which may disappear with training in muscle re-education. It may represent some synaptic dysfunction in the spinal cord, or simply be a poorly organized attempt to produce motion from many muscle groups when there is a considerable degree of weakness.

Electromyograms may also be used as a rough quantitative measurement of voluntary power during active contraction of muscle. There is a correlation between muscle strength and the voltage of action potentials, although it probably is not so trustworthy a quantitative measurement as an ergogram. Because of this approximate quantitative measurement which is possible, electromyography has been used to evaluate the effectiveness of various physical agents on the degree of muscle spasm in poliomyelitis. Results, to date, however, have been negative, there being no strong preference for any of the physical agents commonly used, including intermuscular prostigmine.

Electromyography has been used extensively in the study of peripheral nerve injuries during the past

ten years. It has been found possible by this method to detect early signs of reinnervation before there is clinical evidence of regeneration; and to determine the extent of nerve damage, particularly in cases of compression or stretch injuries, where the presence of actual potential indicates that the lesion is not complete. It is also useful where there is suspected hysteria or malingering, as normal potentials may be discharged from a muscle which is apparently paralyzed. The greatest value of electromyography is probably in following the course of regeneration of peripheral nerves to determine the extent of reinnervation of muscles.

In patients with pain in the upper extremity and suspected protusion or rupture of a cervical or intervertebral disk, electromyograms have shown the presence of discharges from resting muscles, presumably from irritation of cervical roots. In the case of disk lesions, these discharges are often increased with movements of the neck. By reference to the common root supplying the muscles from which this abnormal activity is recorded, the electromyogram has been found an aid in localization of the lesion. Similar electromyographic tracings can be obtained from patients with lumbar intervertebral disk lesions. The tracing, of course, does not give a specific diagnosis of disk lesion, but simply suggests irritation of one of the lumbosacral roots. Because of the overlap of segmental innervation of the muscles of the leg, the electromyogram is of less value in localizing the level of the lesion.

In these progressive degenerative diseases of the anterior horn cells, the electromyogram shows a very



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characteristic abnormality. Spontaneous discharges in these conditions produce diphasic spikes of very irregular voltage and frequency. They are often picked up from muscles free of visible fasciculations, so that a general diffuse degenerative disease may be detected at an early stage, when clinical signs reveal only localized muscle atrophy.

Electrical recording of the tremor characteristic of Parkinson's disease is so constant that the electromyogram is of diagnostic importance. There are found to be alternate discharges from antagonistic muscle groups with a regular frequency of about six per second, the bursts of electrical activity having a fairly normal appearance as to frequency and voltage. As this type of tremor can rarely be reproduced voluntarily, it is possible to differentiate such tremor from that of hysterical origin.

Patients with spasmodic torticollis show diffuse high-voltage discharges from the muscles involved, as would be suspected from clinical examination. The amount of electrical activity may be used to evaluate the effectiveness of various therapeutic agents, such as drugs or locally injected chemicals.

There is no characteristic abnormality of the electromyogram in muscle dystrophy. No fibrillation potentials are recorded, there simply being a gradual decrease in the amount of voltage discharged during voluntary action. The completely paralyzed muscles are electrically silent.

Although the fatigue characteristics of myasthenia gravis can be demonstrated by means of electromyography, the records do not have an appearance which is specific for this disease, so that it is not an important diagnostic tool.

Summary

1. Electromyography has been found useful in studying the pattern of motor activity in normal and paretic muscles, particularly in poliomyelitis and peripheral nerve injuries.

2. Degrees of spasticity, rigidity, and tremor may be measured semi-quantitatively by this method.

3. Information of diagnostic importance is obtained from patients with progressive muscle atrophy, Parkinson's disease, peripheral nerve injuries, and hysteria.—Abstracted by ALBERT A. MARTUCCI, M.D., chairman of Commission on Physical Medicine and Rehabilitation of MSSP.

"Well over a billion dollars of the cost of the health system is paid out of general taxation. It is one reason why British pay the world's highest income and sales taxes. Indirectly, it is a factor in the high costs which have cut sales of British goods in world markets."—The late E. T. LEECH, editor, *The Pittsburgh Press*.

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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, *Am. J. M. Sc.* 209: 33-41 (Jan.) 1945.

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BRITISH DOCTORS CRITICIZE NATIONAL HEALTH SERVICE

British doctors warn of an influx of unqualified specialists encouraged by the National Health Act, according to an editorial in the *Journal of the American Medical Association*.

The editorial is based on a review of the first year of enforcement of the act which was published recently in *The Practitioner*, a leading British medical journal. The English publication quoted doctors in various fields.

"New entrants wield," an obstetrician writes, "the forceps, often fearfully, sometimes frightfully, not because of a basic interest in obstetrics, but because of sheer financial necessity imposed upon them by the workings of the Health Act."

A surgeon wrote: "When all are entitled to hospital treatment and all may demand the care of a specialist, there is a danger that hospitals may be asked to undertake work for which they are as yet unfitted and that men insufficiently trained may be accepted as specialists."

According to the review, other doctors find many shortcomings in the service.

"Practically all hospitals in Great Britain now are the property of the state," *The Journal* editorial says. "Voluntary and municipal controls are abolished. The majority of general practitioners provide medical service for a capitation fee.

"However, the Service Act did not provide additional beds and physicians, and long waiting lists for hospital inpatients remained and in some instances increased. Patients who did wish to take advantage of the so-called 'free' treatment suffered a financial disadvantage because of the cost assessed to private beds.

"Administration of the service is by regional hospital boards, which increased, as is inevitable in ventures of this type, the number of officials in hospitals. It also raised problems associated with the position of the consultant. Who is a consultant and what is his value seem open to question. Apparently his status still is unsatisfactorily settled.

"The general practitioner also found a changed way of living. Those in the service experienced a dwindling of private practice until it assumed comparatively insignificant proportions. Some practitioners, of course, became busier than before because of the capitation fee system.

"According to *The Practitioner*, the capitation system caused the practitioner to take on his list as many as he could, which meant, of course, that thoroughness was sacrificed. The more conscientious, thorough physicians were at a disadvantage financially because they did not see as many patients. Another element that was not pleasing was the change in atmosphere; patients often made unreasonable demands which they expected to be met by the physician because 'he was paid to do so.'"

"Finances, of course, receive consideration in more than one section in this review by *The Practitioner*. One phase of consideration reveals the abuses inherent in all acts of this kind. Another phase is concerned with the wages, increased number of officials, and attempts on the part of hospitals to repair or build struc-

tures which declined during the war years and the years following.

"Still another phase of the financial aspect of this service reveals that it brought anxiety and financial hardship to the young surgeon not yet started on his career, some security to the surgeon just started, but financial hardship to the mature surgeon who had attained recognition.

"Apparently the ones who benefited most and consistently were those who were added to the government payrolls for administrative purposes. Certainly the physicians in general did not improve their financial status and the patients did not gain more for the money that they spent in taxes or would have to spend in long dreary years in the future."

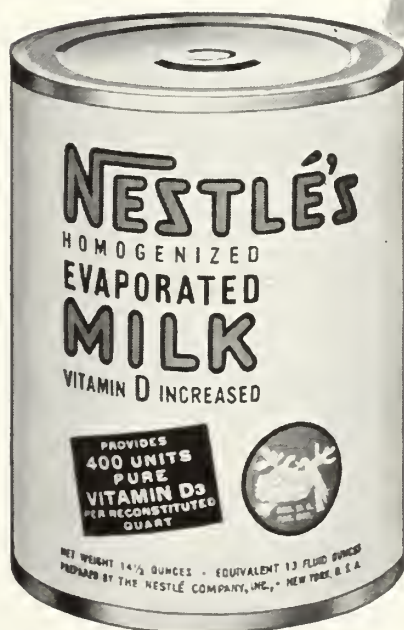
YOUR PUBLIC RELATIONS

There can be little argument that the public has a legitimate interest in medical problems and progress. This interest to a very great extent has been aroused and is being encouraged by the lay press. There is an obviously increasing incidence of medical articles and science columns particularly in newspaper and magazine fields. The demand for this type of information has resulted in the formation of a group of writers known as the National Association of Science Writers. Many of its 103 members devote a major portion of their time to medical subjects. Careful surveys of reader interest conducted by *The Saturday Evening Post* have shown that medical articles, health and hygiene in 1946 led the list and all surveys this year show them thus far in the same position. In discussing this great reader interest, Mr. Steven M. Spencer,* science and medical editor of the *Post*, says that one of the complaints most frequently heard is that "the doctors don't tell us anything. They're in such a big hurry they don't bother to explain what it's all about." There is no doubt truth in this statement and it is important for all physicians to evaluate their own practice in this matter and find out if in the busyness of office practice the word of explanation here and there is being neglected. In the campaign of public education now being carried on by the AMA it is the individual doctor and his contact with patients that is the greatest single force of influence. "It is more and more to the advantage of the medical profession today," says Mr. Spencer, "to meet the public halfway on these matters, for it is the public to which the doctors must look for an increasing share of support for medical education and research. As taxpayers providing government grants and as voluntary contributors to a growing list of special campaigns, the people want to be kept informed on medical affairs and they want to be assured that the doctors examine both sides of medical economics questions. If the American medical profession is to have an electorate favorably disposed toward the physicians' views on compulsory health insurance, for example, that electorate must be kept sold on the American medical profession."—*Connecticut State Medical Journal*.

* SPENCER, S. M.: Interpreting Medicine for the Layman, *New York Med.*, Sept. 20, 1949.

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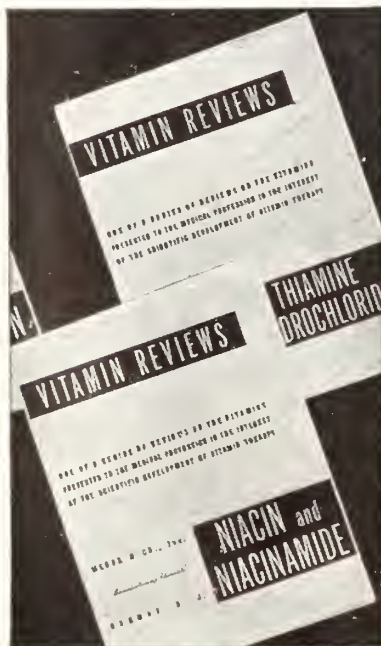
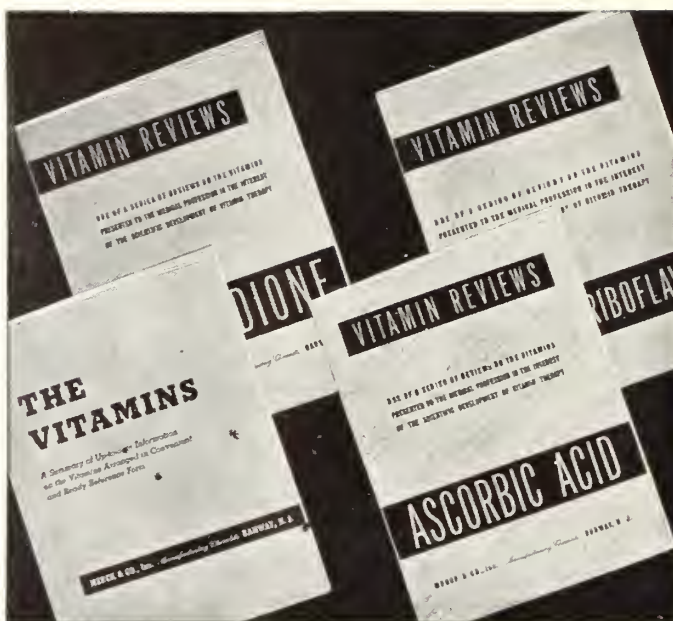
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- ➡ Methods of administration.
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MEDICAL NEWS

Birth

TO DR. AND MRS. ANTHONY J. KAMEEN, of Wilkes-Barre, a daughter, Marilyn Claire Kameen, January 7.

Engagements

MISS ELSIE DUPUY GRAHAM HIRST, daughter of Dr. and Mrs. John Cooke Hirst, to Mr. William Toy Boericke, all of Philadelphia.

MISS MARY ELLISON, daughter of Dr. and Mrs. Richard T. Ellison, of Philadelphia, to Mr. Henry Cornwall Hastings, of Springfield, Mass.

Marriages

MISS CATHERINE EVANS BABCOCK, daughter of Dr. and Mrs. W. Wayne Babcock, of Bala, to Mr. Egil Amlie, of Oslo, Norway, February 25.

MISS MARY HERITAGE WALKER, daughter of Dr. and Mrs. Dudley Pomp Walker, of Bethlehem, to Mr. A. Harden Coon, Jr., of Kingston, February 14.

MISS ABBIE BUCKMAN, daughter of Dr. and Mrs. Lewis T. Buckman, of Glen Summit, to Mr. John Vernon Giegson, of Tegucigalpa, Honduras, C. A., Dec. 28, 1949.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ **Earl S. Reimer**, Northampton; Hahnemann Medical College and Hospital of Philadelphia, 1948; aged 27; died Jan. 22, 1950, as a result of injuries received in an automobile accident. After serving his internship at the Allentown Hospital, he became a member of the staff of the hospital. During World War II he was on active duty with the Navy. He had opened an office for the practice of medicine less than three weeks prior to his death and had been elected to membership in the Lehigh County Medical Society in November, 1949. He is survived by his widow, his parents, and a son.

○ **Simon H. Ratner**, Pittsburgh; University of Pittsburgh School of Medicine, 1912; aged 59; died Feb. 10, 1950, in Miami, Fla. He studied also at the Universities of Vienna, Berlin, and Prague, and at Philadelphia's Chevalier Jackson Clinic. Dr. Ratner was chief of bronchoscopy at the Montefiore Hospital and consultant in otolaryngology at the Leech farm, Pittsburgh Tuberculosis Hospital. During World War I he served as a captain in the Canadian Army Medical Corps. He was a member of the American Academy of Ophthalmology and Otolaryngology. Dr. Ratner is survived by his widow, a brother, and two sisters.

Robert P. Sturr, Philadelphia; Jefferson Medical College of Philadelphia, 1916; aged 56; died Feb. 11, 1950, at Oceanside, Calif. He also practiced medicine in Haddon Heights, N. J., where his home was located.

Dr. Sturr was a staff member at Jefferson and Graduate Hospitals, and was chief radiologist at the Camden County General Hospital at Lakeland, N. J. He served with the U. S. Army Medical Corps during World War I, and was a commander in the Navy in the second war. His widow and two sons survive.

○ **Oliver P. Stoey**, Newville; Jefferson Medical College of Philadelphia, 1881; aged 93; died Feb. 6, 1950, following an attack of pneumonia. Dr. Stoey began his practice on horseback, carrying his medical supplies in saddlebags, and ended it 60 years later, at age 85, driving an automobile. He maintained his active membership and interest in Cumberland County Medical Society until one year ago, when he became an associate member. His survivors include two sons and two daughters.

○ **Frederick A. Muschlitz**, Wilkes-Barre; Jefferson Medical College of Philadelphia, 1911; aged 62; died suddenly Jan. 25, 1950. Prior to his retirement two years ago due to a coronary condition, Dr. Muschlitz was a member of the surgical staff of Pittston Hospital for 27 years and more recently consultant. He was a member of the National Gastroenterological Association. His widow and a daughter survive.

William A. Arnold, Pittsburgh; University of Pittsburgh School of Medicine, 1901; aged 81; died Feb. 7, 1950, at the home of a daughter in Camp Hill, where he has lived since 1944 when he gave up his medical practice. Dr. Arnold maintained a tuberculosis dispensary in the Lower Allegheny Valley for many years. He is survived by another daughter and a son, also a sister and a brother.

○ **Clark M. Smith**, Plumville; Ohio Medical University, Columbus, 1903; aged 71; died Feb. 5, 1950. He had practiced medicine for more than 45 years and was active in affairs of his home community and the county. During World War I he served as a medical officer in France. He is survived by his widow, two sons, and a sister.

○ **Fairfax G. Wright**, Chambersburg; University of Maryland School of Medicine, Baltimore, 1903; aged 71; died Feb. 13, 1950. Dr. Wright was a member of the medical staff of Chambersburg Hospital and for a time was chief surgeon. He was a Fellow of the American College of Surgeons. He served in World War I.

○ **Joseph C. Hess**, Philadelphia; Jefferson Medical College of Philadelphia, 1924; aged 56; died Feb. 4, 1950, after a long illness. Dr. Hess served on the staffs of Graduate, American Stomach, Episcopal, and Doctors' Hospitals. He was a veteran of World War I. Two brothers and two sisters survive.

○ **Peter E. Fagan**, Hazleton; Jefferson Medical College of Philadelphia, 1909; aged 65; died Feb. 17, 1950. Dr. Fagan was medical examiner for the city school district for 21 years, and served as chief surgeon for

the Jeddo Highland Coal Company for many years. During World War I, he served as a captain with the U. S. Army Medical Corps. Surviving are his widow, six sons, one daughter, three sisters, and a brother.

W. James C. Lamb, Homestead; Georgetown University School of Medicine, Washington, D. C., 1903; died Feb. 6, 1950. He had practiced medicine for 43 years. Surviving are his widow, a son, and two daughters.

○ Guy D. Engle, Wilkesburg; University of Pennsylvania School of Medicine, 1901; aged 73; died Feb. 6, 1950. Dr. Engle was an associate in medicine at Columbia Hospital and had been a general practitioner for nearly 50 years. Two daughters survive.

○ Howard S. Reiter, McKeesport; University of Pittsburgh School of Medicine, 1920; aged 53; died Jan. 13, 1950. Dr. Reiter served during World War II, prior to which he was located in Brownsville.

○ Wilbur J. Hawkins, Millsboro; College of Medicine and Surgery, Chicago, Ill., 1901; aged 72; died Jan. 23, 1950. His son, Wilbur J. Hawkins, Jr., practices medicine at Fredericktown.

○ Richard A. Caldwell, Pittsburgh; Hahnemann Medical College and Hospital of Philadelphia, 1938; aged 37; died Dec. 22, 1949.

○ John C. Kachline, Quakertown; Medico-Chirurgical College of Philadelphia, 1901; aged 75; died in December, 1949.

Miscellaneous

DR. PAUL R. HAWLEY has resigned as Chief Executive Officer of the Blue Cross and Blue Shield Commissions to become the Director of the American College of Surgeons, effective March 1.

THE KESSLER INSTITUTE FOR REHABILITATION, West Orange, N. J., will hold its fourth annual Amputee Conference on April 20, 21, and 22. Further details may be had by writing to Dr. Henry H. Kessler at the Institute.

DR. DONALD GUTHRIE, of the Guthrie Clinic at Sayre, was the speaker at the February 7 meeting of the Dauphin County Medical Society. His topic was "The Diagnosis and Surgical Treatment of Benign and Malignant Lesions of the Breast."

THE SCHOOL OF MEDICINE, UNIVERSITY OF PITTSBURGH, will offer an intensive postgraduate course in gastroenterology, April 3-6, 1950 (inclusive). A bulletin describing the course is being prepared and will be sent to the secretary of each county medical society in the near future.

"PRACTICAL PROBLEMS IN GENERAL SURGERY" is the subject of a continuation course to be conducted on April 6, 7, and 8 by the Frank E. Bunts Institute and the Cleveland Clinic. For complete program information, write to Frank E. Bunts Educational Institute, 2020 East Ninety-third St., Cleveland 6, Ohio.

THE EASTERN SECTIONAL MEETING OF THE AMERICAN CONGRESS OF PHYSICAL MEDICINE will be held in Washington, D. C., on April 29. The afternoon session, starting at 2 p.m., will be conducted at the George Washington University Hospital, 901 Twenty-third Street, N. W., and following dinner at the Willard Hotel, the evening session will consist of a panel discussion. Inquiries should be directed to Herman L. Rudolph, M.D., Section Secretary, 400 North Fifth St., Reading, Pa.

THE BOARD OF REGENTS OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS is offering a cash prize award of \$250 to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest diseases. The winning contribution will be selected by a board of impartial judges, and the first award will be made at the forthcoming annual meeting of the college to be held in San Francisco, June 22-25, 1950. Additional information may be obtained from the Executive Secretary of the College, 500 North Dearborn St., Chicago 10, Ill.

THE THIRD ANNUAL POSTGRADUATE COURSE IN DISEASES OF THE CHEST, sponsored by the American College of Chest Physicians, Pennsylvania Chapter, and the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, Philadelphia, April 10 to 14. This course will emphasize the recent developments in all aspects of the diagnosis and treatment of diseases of the chest. The course is open to all physicians, although the number of registrants will be limited. The tuition fee is \$50, and applications will be accepted in the order in which they are received. Applications should be sent to: American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Ill.

THE PUBLIC HEALTH SURVEY MADE RECENTLY IN PENNSYLVANIA will be an important subject considered at the fifty-eighth annual meeting and conference of the Pennsylvania Tuberculosis and Health Society (formerly the Pennsylvania Tuberculosis Society), which is to be held in Reading, Wednesday, Thursday, and Friday, May 24, 25, and 26. Headquarters will be at the Abraham Lincoln Hotel.

The Pennsylvania Trudeau Society, medical section of the Pennsylvania Tuberculosis and Health Society,



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and the Pennsylvania Conference of Tuberculosis Secretaries will hold their annual meetings at the same time.

THE ANNUAL MEETING OF THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY will be held May 12, 13, and 14, 1950, at the Bedford Springs Hotel, Bedford, Pa.

In addition to the star-studded formal program, twelve study clubs will be conducted, to run concomitantly with the scientific sessions. There will also be an open forum, an "Information Please" type of session, with the topics "Refraction Difficulties in Presbyopia" and "Common Office Procedures in Otorhinolaryngology."

The incumbent officers are: president, Daniel S. DeStio, M.D., Pittsburgh; president-elect, Jay G. Linn, M.D., Pittsburgh; secretary, Benjamin F. Souders, M.D., Reading.

THE FIRST ORGANIZED COURSE IN THE MEDICAL ASPECTS OF ATOMIC ENERGY began February 8 at Jefferson Medical College, Philadelphia. Opening the course was a lecture on "The Problem of the Physician in an Atomic Disaster" by Colonel James P. Cooney, Army Medical Corps officer, who is chief of the Radiologic Branch, Division of Military Application, Atomic Energy Commission. The course, to be repeated annually, will consist of 18 hours of instruction to students on the junior level, with 14 hours to be given by the departments of radiology, medicine, and surgery of Jefferson Medical College. The other four hours

will be given by Army experts in atomic medicine. These, in addition to Colonel Cooney, will be Lieutenant Colonel Larry Smith, professor of military science and tactics at Jefferson, and Major Gerald M. McDonnell, chief of the Medical Branch, Radiologic Defense Division, Armed Forces Special Weapons Project.

THE FOLLOWING NAMED SURGEONS FROM PENNSYLVANIA WERE MADE FELLOWS AND ASSOCIATE FELLOWS in the United States Chapter, International College of Surgeons, at the convocation ceremonies held during the Fourteenth Annual Assembly of the College in Atlantic City, N. J., Nov. 7 to 11, 1949:

Certified Fellows: Henry C. Thel, Aliquippa; Clarence A. Holland and Guy L. Kratzer, Allentown; Irvan A. Boucher, Altoona; Joseph V. Ross, Berwick; Clarence E. Moore and Gilbert L. Dailey, Harrisburg; Joseph W. McHugh, Jr., and Richard P. Zimmerman, Johnstown; Frank R. Bondi, McKeesport; Isaac Andrussier, Frank Glauser, Frederick Harbert, William E. Krewson, Louis Lehrfeld, Burech Rachlis, William A. Reishtein, Walter Sussman, Maurice H. Alexander, John W. Egovalle, Thomas J. English, Otto P. Griffin, Alma D. Morani, Ned T. Raker, John C. Ullery, and Leopold S. Vaccaro, all of Philadelphia; Robert E. Brant and Harold A. Conrad, Phoenixville; Max Antis, William A. Barrett, Jr., Hyman E. Canter, Samuel Goldstein, David Katz, Harold G. Kuehner, Benjamin Levant, James V. Scott, Carl C. Yount, and Theodore S. Swan, all of Pittsburgh; Frank A. Lorenzo, Punxsu-

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tawney; Matthew J. Boland and Malcolm Z. Gearhart, Reading; and Timothy F. Moran, Scranton.

Associate Fellows: Kermit K. Kistler, Allentown; Hugh I. Stitt, Kittanning; James L. Auslander, McKeesport; Robert C. Hughes, Paoli; Henry L. Gowens, Jr., Thomas J. O'Neill, and Hymen D. Stein, Philadelphia; John E. Gotwals, Phoenixville; M. Morton Gratz, Pottstown; Lawrence G. Van Loon, Reading; Lloyd D. Rugh, Tarentum; and John L. Dorris, Wilkes-Barre.

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For Rent.—Doctor's offices for rent because of death. Well established practice. Excellent opportunity. Write MRS. C. W. SCHWALM, Shoemakersville, Pa.

For Sale.—Modern house and office for rural and suburban general practice in southern Cumberland Valley. Will introduce. \$40,000. Terms. Write Dept. 178, PENNSYLVANIA MEDICAL JOURNAL.

Anesthesiology Residency Available.—Approved by American Board. Open to graduates of approved medical schools with one-year internship. Apply DIRECTOR OF ANESTHESIA, Mt. Sinai Hospital, Philadelphia 47, Pa.

Wanted.—Physicians under 40 years. Insurance examining. Reply giving personal data. PHILADELPHIA-UNITED LIFE INSURANCE COMPANY, Girard and Ridge Avenues, Philadelphia 30, Pa.

Wanted.—Allergist as associate or partner to otolaryngologist, Philadelphia, Monday, Wednesday, Friday. In reply state age, experience, hospital affiliations. Write Dept. 182, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Locum tenens for six weeks beginning April 20. Must have Pennsylvania license and car. Salary open. Write Dept. 184, PENNSYLVANIA MEDICAL JOURNAL.

Wanted Immediately.—Two house physicians for 116-bed general hospital. Approved by the American College of Surgeons. Excellent opportunity. Good salary. Apply SUPERINTENDENT, Mercy Hospital, Johnstown, Pa.

Wanted.—Two medical residents starting July 1 for 400-bed general hospital that had 2644 medical and pediatric admissions last year. Write for application blank to RESIDENT COMMITTEE, ST. LUKE'S HOSPITAL (non-sectarian), Bethlehem, Pa.

Available.—Very active semi-rural practice in town of 1100 in York County. Near hospital. No sale charge except for few drugs. Office space and equipment for rent, very reasonable. Leaving to specialize. Write Dept. 181, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Alert, young general practitioner as locum tenens for one year in town of 7000 near Altoona. Include reference letters and photographs in first letter. Will notify prior to May 1, 1950. Write Dept. 185, PENNSYLVANIA MEDICAL JOURNAL.

Assistant Wanted.—General practitioner and roentgenologist needs an assistant due to ill health. Office and location established over fifty years. Ear, nose, and throat man preferred. Excellent X-ray equipment available. Write Dept. 175, PENNSYLVANIA MEDICAL JOURNAL.

Residents Wanted.—Surgical and medical residencies in 135-bed general hospital, 12 months ending June 30, 1951. Not approved for training, but wealth of experience. Salary \$300 a month and maintenance. Pennsylvania registration required. Write LEWISTOWN HOSPITAL, Lewistown, Pa.

Medical Literary Research Bureau.—Information, abstracts, bibliographies from old and current medical literature. Translations and photostatic copies provided. Ample reference facilities. REYNOLDS HAYDEN, M.D., Director, (Capt., Med. Corps, U.S.N., Ret.) 5411 Potomac Ave., N.W., Washington 16, D. C.

For Sale.—Modern office and home with active established general practice. Added income from industrial, insurance, and railroad contacts. Location—large industrial community, one-half hour from downtown Pittsburgh. Leaving to specialize. Write Dept. 176, PENNSYLVANIA MEDICAL JOURNAL.

Residents and Interns Wanted.—Resident physician with Pennsylvania license. Salary \$400 per month with full maintenance. Interns—salary \$200 per month with full maintenance. 191-bed general hospital. Fully approved by A.C.S. Write ADMINISTRATOR, Hahnemann Hospital, Scranton, Pa.

Wanted.—General practitioner for rural section of Huntingdon County. Area includes Marklesburg, Entriken, and James Creek. House available. Community organizations very interested in obtaining physician. Contact either MISS BETTY G. BEANER, Secretary, Lincoln Grange 94, Entriken, Pa., or MRS. FLORA J. GARNER, P. M., James Creek, Pa.

For Sale.—General practice with all supplies and equipment for price of equipment alone: Includes 100 KV, 100 MA X-ray and fluoroscopic unit with all accessories. Office suite of six rooms in central location of small industrial community 30 miles west of Philadelphia. Price, \$5,000. Write Dept. 183, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Fully equipped modern office of recently deceased young physician. Practically new 100 M.A. X-ray (G. E.), two Whirlpool Baths, diathermy, laboratory equipment, waiting room and office furniture. Well established practice in thriving mining community. Contact or write MRS. WILBUR J. HAWKINS, JR., P. O. Box 487, Fredericktown, Pa.

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Wanted.—Pennsylvania physician for 750-bed tuberculosis hospital on main highway and Pennsylvania Railroad. Some knowledge of tuberculosis preferred, but not necessary. Pennsylvania license or reciprocity required. Apartment for single man or man and wife. All phases of tuberculosis including major chest surgery. Retirement privileges. Inquire MEDICAL DIRECTOR, State Tuberculosis Sanatorium, Cresson, Pa.

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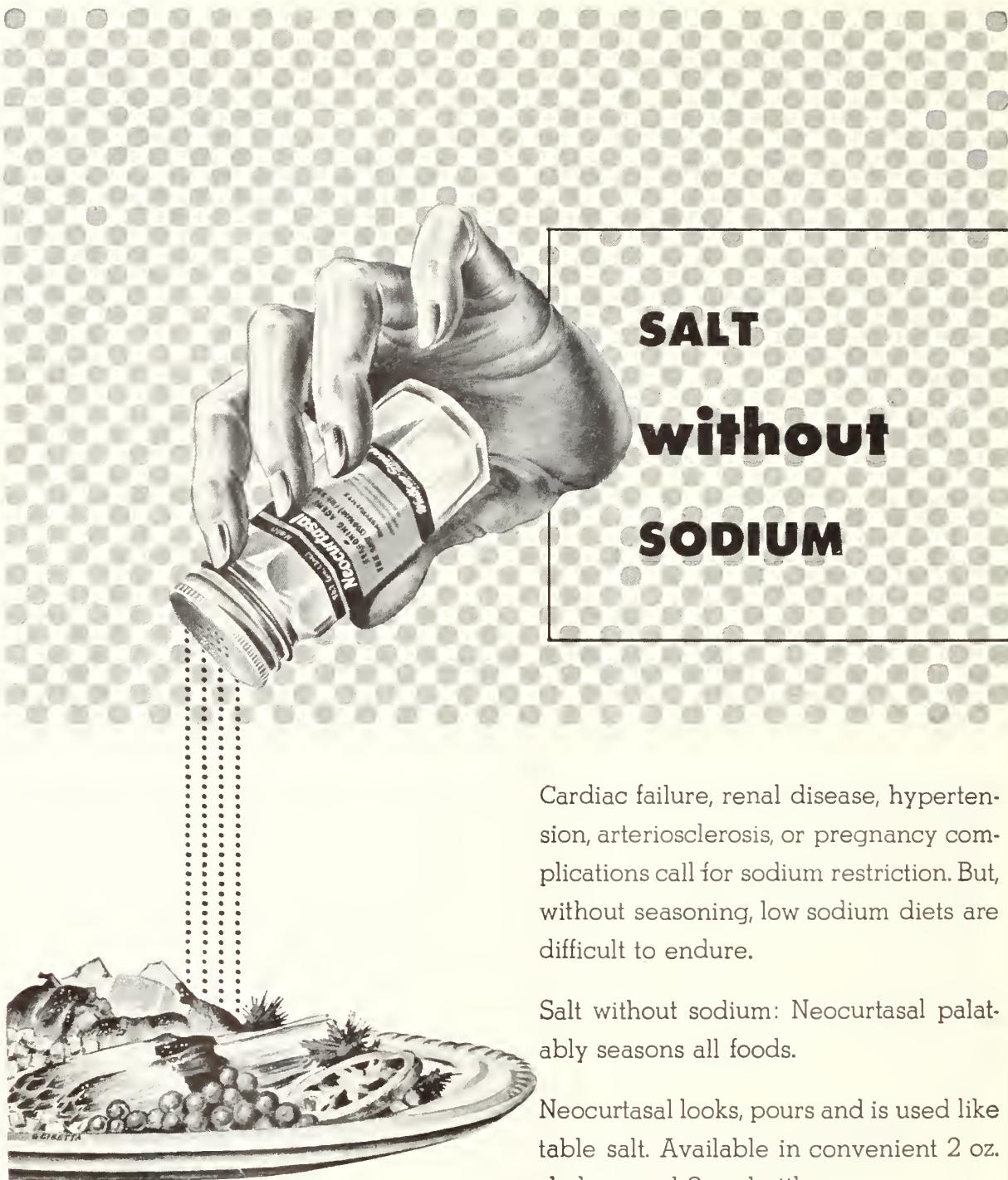


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BOOK REVIEWS

Synopsis of Hernia. By Alfred H. Iason, M.D., Attending Surgeon, Adelpia Hospital; Director of Surgery, Brooklyn Hospital for the Aged; Instructor in Anatomy, New York Medical College. 500 pages with 98 figures. New York: Grune & Stratton, 1949. Price, \$6.50.

This competent little book is the author's attempt to encompass a wealth of material within its covers. Considering the limitations that have been imposed in part by lack of space, it is not to be wondered that at all times a clear picture is fairly well achieved of the subject matter. The text is written in four large sections as follows: (1) general considerations, classification, and anatomy; (2) external abdominal hernias, inguinal, femoral, and other abdominal hernias; (3) internal hernias, diaphragmatic and other types; (4) rare hernias and recurrent hernias. An appendix and index round out the book. The exposition is usually clear, but probably because of the size of the text, references are not to be found. The printing and illustrations are good. For those graduate and postgraduate students as well as practicing physicians and surgeons who do not already have a book of this nature, this synopsis is recommended.

Operations of General Surgery. By Thomas G. Orr, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kan. Second edition. 890 pages with 1700 step-by-step illustrations on 721 figures. Philadelphia: W. B. Saunders Company, 1949. Price, \$13.50.

In this new edition which appears five years after the previous issue, the author has brought the text up to date with many new drawings which have either been added or replaced those in the previous text. This volume which was originally written for the beginner in surgery as well as the general surgeon continues to serve the purpose for which it was conceived. The book is arranged in twenty-one large groups as follows: wound healing, treatment of fresh wounds, sutures and knots, amputations, the skin and subcutaneous tissues, muscle and bursa, tendons and sheaths, thorax and respiratory system, breast, circulatory system, abdominal incisions, digestive system, hernia, bones and joints, nervous system, sympathetic system, lymphatic system, endocrine system, congenital anomalies, genito-urinary and female reproductive system. References are found at the end of each section, and an index at the end of the book is adequate. The paper, printing, and step-by-

step illustrations of the surgical procedures are good. On the whole this book is recommended for those in need of a book of this nature.

A Textbook of Surgery. By American authors. Edited by Frederick Christopher, B.S., M.D., F.A.C.S., Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Fifth edition. 1550 pages with 1465 illustrations on 742 figures. Philadelphia: W. B. Saunders Company, 1949. Price, \$13.00.

This new edition reflects thoroughly the advances in surgery that have occurred within the past few years since the previous issue. The editor and his collaborators have succeeded in giving the student a concise presentation of the subject matter. The contents of the book are systematically and instructively presented.

A textbook of this type, because there is both competent and authoritative delineation of surgical principles covering the entire field contained within its covers, and because it seems so well organized, may be considered as recommended reading for both student and practitioner.

The author of each section has apparently made some effort to delete obsolete practices from this edition and to include some of the newer developments. This has been so well accomplished that no one section appears more outstanding than the other. However, it is believed that some portions may well have been illustrated, for many times a picture will clarify what may require many words to cover.

Acute Laryngotracheobronchitis. By A. Harry Neffson, M.D. 197 pages with 17 illustrations. New York: Grune & Stratton, 1949. Price, \$5.00.

In this little textbook the author has succeeded in presenting a clear picture of the subject matter in a comprehensive manner. The text is written so that the table of contents is composed of the following chapters: history, incidence, pathology, bacteriology, symptomatology, diagnosis, supraglottic edema, differential diagnosis, treatment, complications, role of various practitioners and specialists, prognosis, and laryngitis associated with exanthemata.

The exposition is usually clear and the printing and illustrations are good. Because of its compactness this book is considered very satisfactory for those for whom it has been written, namely, the general doctor, the pediatrician, and the laryngologist.

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The author has not only drawn upon his own rather extensive experience but presents, in addition, a bibliography of relevant material. An authors' and subject index round out the book. It is recommended for its concise and timely presentation.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

The Development of Gynecological Surgery and Instruments. A comprehensive review of the evolution of surgery and surgical instruments for the treatment of female diseases from the Hippocratic age to the antiseptic period. By James V. Rieci, M.D., Clinical Professor of Gynecology and Obstetrics, New York Medical College; Attending Gynecologist, City Hospital, New York; Consultant in Gynecology and Obstetrics, Beekman-Downtown Hospital; Director of Gynecology and Obstetrics, Columbus Hospital, New York Medical College City Hospital Division. Philadelphia: The Blakiston Company, 1949. Price, \$12.00.

Secretory Mechanism of the Digestive Glands. By B. P. Babkin, M.D., D.Sc., LL.D., F.R.S.C., formerly Research Professor of Physiology, McGill University,

Montreal, Canada; formerly Professor of Physiology in the University of Odessa, Russia, and in Dalhousie University, Halifax. With 233 illustrations. Second edition, revised and enlarged. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1949. Price, \$20.00.

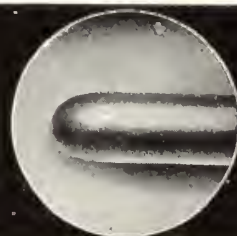
Clinical Pathology—Application and Interpretation. By Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock, Ark. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$6.00.

Electrocardiography—Fundamentals and Clinical Application. By Louis Wolff, M.D., Visiting Physician, Consultant in Cardiology, and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; Associate in Medicine, Harvard Medical School. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$4.50.

Medical State Board Questions and Answers. By R. Max Goepf, M.D., formerly Professor of Clinical Medicine, Graduate School of the University of Pennsylvania, and Professor of Medicine, Woman's Medical College of Pennsylvania, and Harrison F. Flippin, M.D., Associate Professor of Medicine at the Graduate School of the University of Pennsylvania. Eighth edition. Philadelphia: W. B. Saunders Company, 1950. Price, \$7.00.

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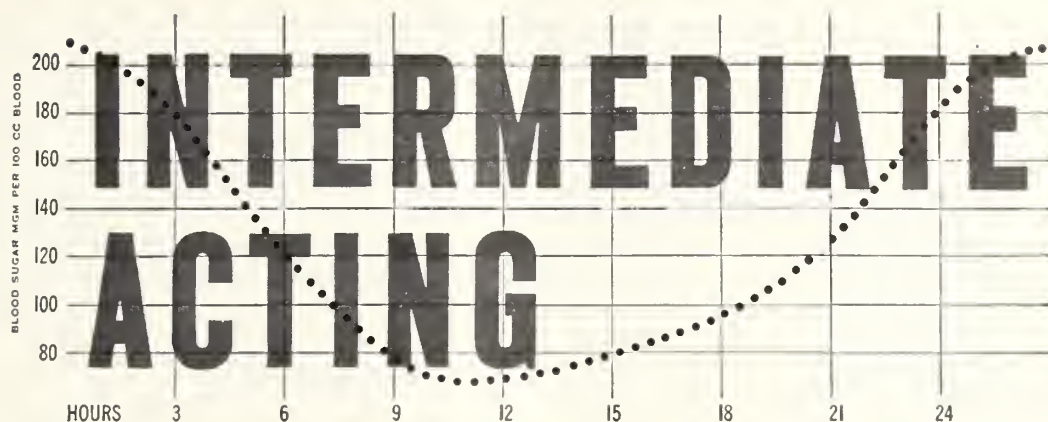
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1. Pohr, J.H., and Colwell, A.R. Arch. Int. Med. 82:54, 1948.
2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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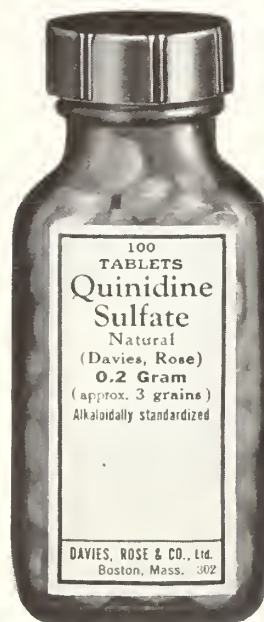
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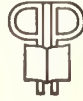
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- 10 a.m. *Allergy from the Rhinologic Standpoint*
Karl M. Houser, Philadelphia
- 11 a.m. *Allergy in Ophthalmology*
Irving H. Leopold, Philadelphia
- 2 p.m. *Biologic and Antibiotic Agents in the Prophylaxis and Treatment of Upper Respiratory Tract Infections*
John A. Kolmer, Philadelphia
- 3 p.m. *Industrial Ophthalmology*
Edmund B. Spaeth, Philadelphia
- 4 p.m. *Deafness*
Edward H. Campbell, Philadelphia
- 8 p.m. *Refraction Difficulties in Presbyopia*
- 9 p.m. *Common Office Procedures in Otorhinolaryngology*

Study Clubs

- Glaucoma Problems* (non-surgical)
Sterling F. Mengel, Moderator; Irving H. Leopold; John S. McGavie
- Audiology* (non-surgical)
James E. Landis, Moderator; Leo G. Doerfler; Eugene T. McDonald
- Tropia Problems* (surgical)
Joseph V. Ross, Moderator; Edmund B. Spaeth; Richard G. Scobee
- Functional Diseases of the Nose*
Carroll Rea McClure, Moderator; Karl M. Houser; Richard G. Hamilton
- Phoria and Tropia Problems* (non-surgical)
James J. Monahan, Moderator; Edmund B. Spaeth; Richard G. Scobee
- Paul C. Craig, Moderator; Irving H. Leopold; John B. McMurray; Scott Sterling
- Lewis T. Buckman, Moderator; Matthew S. Ersner; Francis L. Lederer; Thomas B. McCollough

Saturday, May 13, 1950

- 9 a.m. *Audiology and Hearing Aids*
Maurice Saltzman, Philadelphia
- 10 a.m. *Reasons for Failure in Tropia Surgery*
Richard G. Scobee, St. Louis
- 11 a.m. *"E. N. T. Essentially Negative": Avoidance of Pitfalls in Otolaryngology*
Francis L. Lederer, Chicago
- 2 p.m. *Serious Ocular Affections of the Newborn*
Frank D. Costenbader, Washington, D. C.
- 3 p.m. *The Maginot Line of Otology: Dependence Upon Antibiotics in Suppurative Middle Ear Disease—Facts and Fancies*
Francis L. Lederer, Chicago
- 4 p.m. *The Significance of Vertical Components in Lateral Tropia*
Richard G. Scobee, St. Louis

- Emergencies in Otorhinolaryngology*
Daniel S. DeStio, Moderator; Raymond E. Jordan; Joseph P. Atkins
- Cataract Problems* (surgical)
Jay G. Lim, Moderator; Wilfred E. Fry; Lewis T. Wolf
- Treatment of Acute Sinusitis* (non-surgical)
Samuel T. Buckman, Moderator; Francis L. Lederer; Thomas B. McCollough
- Cataract Problems* (non-surgical)
Robert E. Shoemaker, Moderator; Glen Gregory Gibson; William T. Hunt, Jr.
- Non-Surgical Treatment of Acute and Chronic Otitis Media*
Charles H. LaClair, Jr., Moderator; Thomas F. Furlong, Jr.; J. McClure Tyson

Sunday, May 14, 1950

- 9 a.m. *Neuro-ophthalmology. The Syndrome of the Cavernous Sinus*
Frank B. Walsh, Baltimore
- 10 a.m. *Chronic Secretory Otitis Media and Its Complications*
Raymond E. Jordan, Pittsburgh
- 11 a.m. *Ophthalmoscopic Interpretation of Retinal Vascular Disease*
John E. L. Keyes, Cleveland

- Common Office Procedures in Ophthalmology*
Benjamin F. Souders, Moderator; Frank D. Costenbader; P. Robb McDonald
- Differential Diagnosis E. N. T.* (non-surgical)
William J. Hertz, Moderator; Benjamin H. Shuster; A. Boyd Miller

REGISTRATION FEES

Member Registration (including entertainment, cocktails, dinner, dance and smokes)	\$10.00
Guests	5.00
Study Clubs (each)	2.00

HOTEL RATES

Bedford Springs Hotel (American Plan)	
Per person	\$14.00
Per couple	24.00
Reservations should be made now by writing directly to the hotel.	

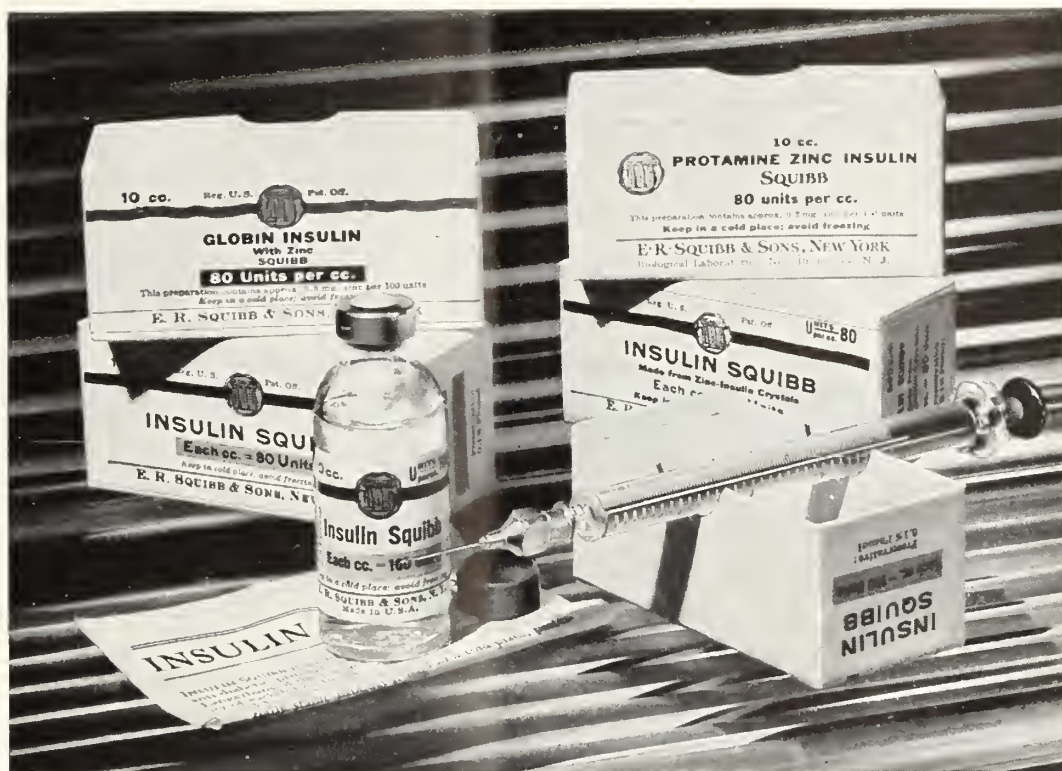
Golf Tournament, 2 p.m., May 11, for early arrivals

LIST OF COUNTY MEDICAL SOCIETIES OF PENNSYLVANIA

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS
Adams	Samuel A. Kirkpatrick, New Oxford	Raymond M. Hale, Jr., Arendtsville	Monthly
Allegheny	Paul G. Bovard, Tarentum	William F. Brennan, Pittsburgh	Monthly†
Armstrong	Calvin E. Miller, Jr., Kittanning	Cyrus B. Slease, Kittanning	Monthly*
Beaver	William T. Rice, Rochester	J. Willard Smith, Beaver Falls	Monthly
Bedford	Harry A. Shimer, Bedford	L. Quentin Myers, Everett	Monthly
Berks	Matthew J. Boland, Reading	Clair G. Spangler, Reading	Monthly
Blair	Elwood W. Stitzel, Altoona	George R. Good, Altoona	Monthly*
Bradford	Joseph B. Cady, Sayre	Dominic S. Motsay, Sayre	Monthly
Bucks	Arthur J. Ricker, New Hope	William I. Westcott, Doylestown	6 a year
Butler	Edward C. Lutton, Butler	J. Van S. Donaldson, Butler	Monthly*
Cambria	Thomas J. Cush, Johnstown	Joseph W. Raymond, Johnstown	Monthly
Carbon	Marvin Evans, Lansford	John L. Bond, Lehighton	Bimonthly
Centre	John H. Light, Center Hall	Hiram T. Dale, State College	Monthly
Chester	Julius Margolis, Coatesville	Francis Jacobs, West Chester	Monthly
Clarion	Harrison M. Wellman, St. Petersburg	James M. Hess, Tylersburg	Quarterly
Clearfield	Frances DeBone Taylor, Philipsburg	George C. Covalla, Clearfield	Monthly
Clinton	Forney D. Winner, Lock Haven	David W. Thomas, Lock Haven	Monthly
Columbia	Joseph V. M. Ross, Berwick	Robert Klein, Bloomsburg	Monthly
Crawford	Samuel E. Hoke, Conneaut Lake	Robert G. Pett, Meadville	Monthly
Cumberland	William B. Turner, Carlisle	Richard R. Spahr, Mechanicsburg	Bimonthly
Dauphin	W. Paul Dailey, Harrisburg	Hamblen C. Eaton, Harrisburg	Monthly*
Delaware	Joseph F. Dougherty, Upper Darby	Walter E. Egbert, Chester	Monthly
Elk	Charles A. Hauber, St. Marys	Robert J. Dickinson, Ridgway	Monthly*
Erie	John F. Hartman, Jr., Erie	Russell B. Roth, Erie	Monthly
Fayette	Bruce Montgomery, Fairchance	Rudolph E. Medlen, Uniontown	Monthly
Franklin	Paul A. Clutz, Mercersburg	Earl Glotfelty, Waynesboro	Monthly
Greene	David L. Avner, Greensboro	Grover C. Powell, Waynesburg	Monthly
Huntingdon	John M. Keichline, Jr., Huntingdon	Robert H. Beck, Huntingdon	Monthly
Indiana	George W. Hanna, Homer City	Daniel H. Bee, Indiana	Monthly
Jefferson	Harry J. Robb, DuBois	E. Nicholas Sargent, Falls Creek	Monthly
Juniata	Penrose H. Shelley, Port Royal	Robert P. Banks, Mifflintown	Bimonthly
Lackawanna	Milton J. Goldstein, Scranton	Philip E. Sirgany, Scranton	Weekly
Lancaster	Charles W. Ursprung, Lancaster	Charles P. Stahr, Lancaster	Monthly
Lawrence	Mary Baker Davis, New Castle	Wilbur E. Flannery, New Castle	Monthly
Lebanon	James T. Gallagher, Palmyra	J. DeWitt Kerr, Lebanon	Monthly*
Lehigh	Martin S. Kleckner, Allentown	Pauline K. Wenner, Allentown	Monthly
Luzerne	Louis W. Jones, Wilkes-Barre	Joseph W. Ehrhart, Forty-Fort	Semimonthly*
Lycoming	Louis E. Audet, Williamsport	Raymond A. Davis, Williamsport	Monthly
McKean	Sophronous A. McCutcheon, Bradford	Persis Straight Robbins, Bradford	Monthly
Mercer	Dan Phythyon, Sharpsville	William A. Reyer, Sharon	Monthly*
Mifflin	Samuel L. Woodhouse, Milroy	John R. W. Hunter, Jr., Lewistown	Monthly
Monroe	Paul H. Shiffer, Stroudsburg	Harold B. Flagler, Stroudsburg	4 a year
Montgomery	John D. Perkins, Jr., Conshohocken	Alice E. Sheppard, Pottstown	Monthly*
Montour	James A. Collins, Jr., Danville	John A. Bealor, Danville	Monthly
Northampton	James B. Butchart, Bethlehem	Thomas H. A. Stites, Nazareth	Monthly*
Northumberland	John R. Vastine, Shamokin	Mark K. Gass, Sunbury	Monthly*
Perry	Amos G. Kunkle, Liverpool	Frank A. Belmont, New Bloomfield	Bimonthly
Philadelphia	Henry B. Kobler, Philadelphia	Malcolm W. Miller, Philadelphia	Monthly*
Potter	Clarence E. Baxter, Coudersport	George C. Mosch, Coudersport	Bimonthly
Schuylkill	William T. Leach, Shenandoah	Charles V. Hogan, Pottsville	Monthly
Somerset	George F. Speicher, Rockwood	Harold G. Haines, Berlin	Bimonthly
Susquehanna	Waldron E. Greenwell, Great Bend	Park M. Horton, New Milford	4 a year
Tioga	Sterling C. Basney, Wellsboro	Eleanor Larson, Elkland	Monthly
Venango	Gale H. Walker, Polk	James E. Hadley, Oil City	Monthly
Warren	John E. Thompson, Youngsville	John C. Urbaitis, Warren	Monthly
Washington	Raymen G. Emery, Washington	Albert E. Thompson, Washington	Monthly*
Wayne-Pike	Richard A. Porter, Hawley	Harold W. Koch, Honesdale	Bimonthly
Westmoreland	Russell A. Garman, Jeannette	William E. Marsh, Jeannette	Monthly*
Wyoming	Arthur B. Davenport, Tunkhannock	Helen M. Beck, Tunkhannock	Bimonthly
York	Norman H. Gemmill, Stewartstown	H. Malcolm Read, York	Semimonthly*

* Except July and August.

† Except June, July, and August.



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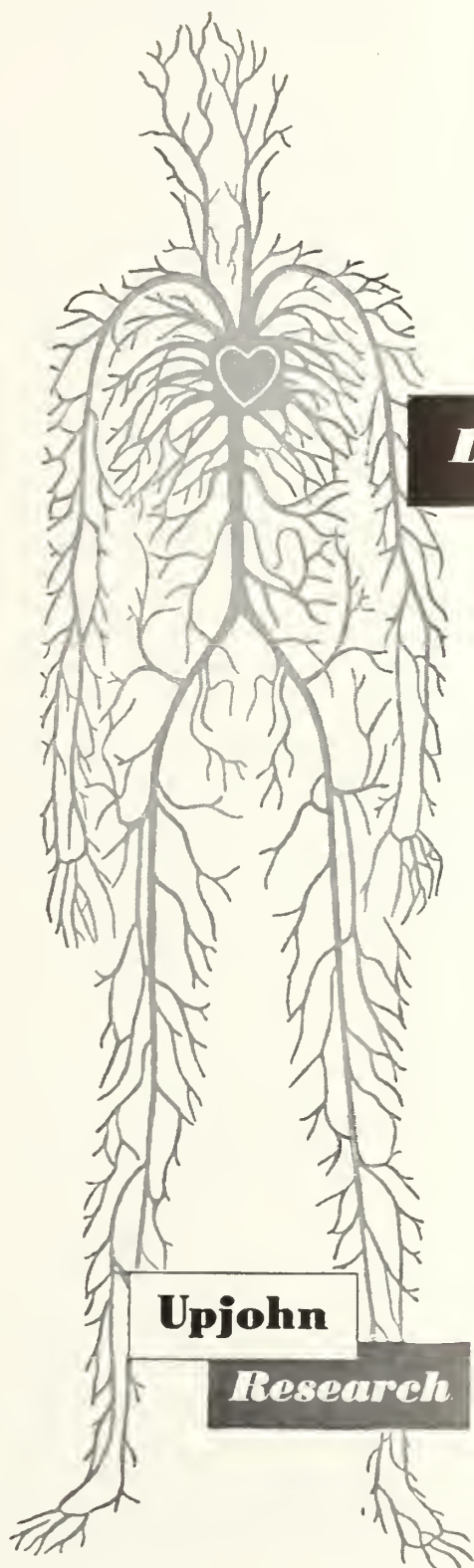
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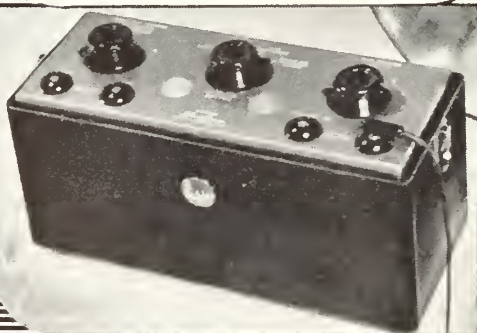
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LETTERS**Secretaries and Editors Conference**

GENTLEMEN:

Just a line to let you know how much I enjoyed being with your officers and the county society representatives in Harrisburg last week. It was an excellent conference, very well planned and conducted. I enjoyed every minute of it.

GEORGE F. LULL, M.D.,
Secretary and General Manager,
American Medical Association.

GENTLEMEN:

I hope that everyone in attendance found the 1950 Secretaries-Editors Conference to be as successful as I did.

RUSSELL B. ROTH, M.D., Secretary,
Erie County Medical Society.

GENTLEMEN:

The Bradford County Medical Society delegation of three enjoyed the 1950 Secretaries-Editors Conference and brought some suggestions home.

The conference was well organized and conducted and for the most part was excellent. It made us feel more than ever before that organized medicine in this Commonwealth is *not* run by reactionaries.

Our profession is living, thinking, and acting and is perhaps, at times, too acutely sensitive to public reaction and attitudes.

A good conference. Thanks!

ORLO G. MCCOY, M.D.
Canton, Pa.

GENTLEMEN:

The Secretaries-Editors Conference held in Harrisburg was very interesting, informative, and most enjoyable.

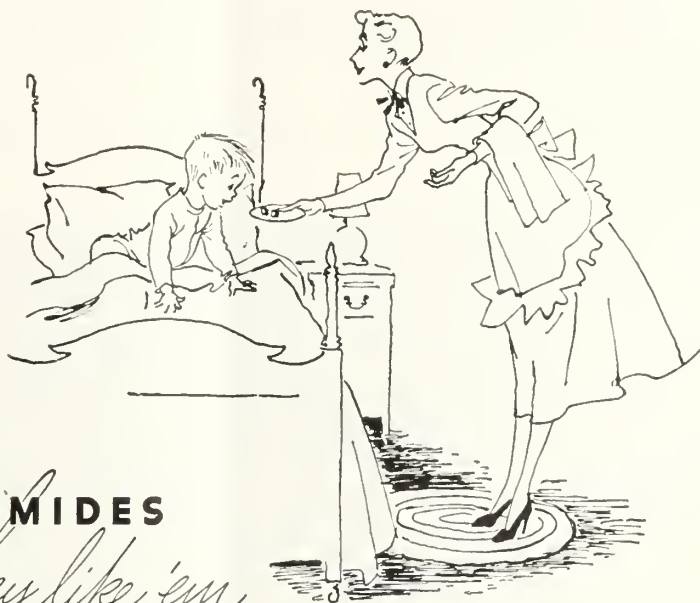
ROBERT KLEIN, M.D., Secretary,
Columbia County Medical Society.

Caution in Use of ACTH

GENTLEMEN:

The Federal Security Agency Food and Drug Administration has warned against the use of ACTH, the adrenocorticotrophic hormone, in the treatment of arthritis, except under the direction of physicians who have special knowledge of its properties. The Food and Drug Administration has not released ACTH for use by the medical profession in general because research has not yet clearly demonstrated the conditions for effective use or ways of avoiding or minimizing the serious side effects which thus far have been associated with its experimental use.

Shipments of ACTH in interstate commerce have been restricted to experts qualified by scientific experience and training to investigate its safety.



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Ten days—June 5 through 16, 1950

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The course will be presented by lectures and practical demonstrations of technics and cases.

The program will include: the classification, causes, clinical and pathological manifestations, prevention, and treatment of the occupational dermatoses; fundamental mechanisms and their implication; the design of pre-use screening tests for the prevention of occupational dermatitis; the occurrence, diagnosis and prevention of occupational skin cancer; and panels on the medico-legal aspects of occupational dermatoses, and the practical dermatological problems of selected industries.

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The following is quoted from a letter written to me on March 2, 1950, by John R. Mote, M.D., medical director of the Armour Laboratories:

"We have bio-assayed the sample of ACTH which you dispatched to us and find that this vial, which is marked 40 milligrams of ACTH, contains the equivalent of 5.7 ± 1.4 per cent milligrams of the Armour Standard ACTH, LA-1-A, as bio-assayed by our modification of the Sayers and Sayers ascorbic acid depletion method."

ABRAHAM COHEN, M.D.,
136 S. 16th St.,
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VA Loan

GENTLEMEN:

Enclosed is check for \$100 in part payment of the loan which I received through the Veterans Loan Fund when I reopened my office after returning from military service.

The loan was of inestimable help to me and I will repay the balance as soon as I can.

_____, M.D.
Pennsylvania.

New Blood Center

GENTLEMEN:

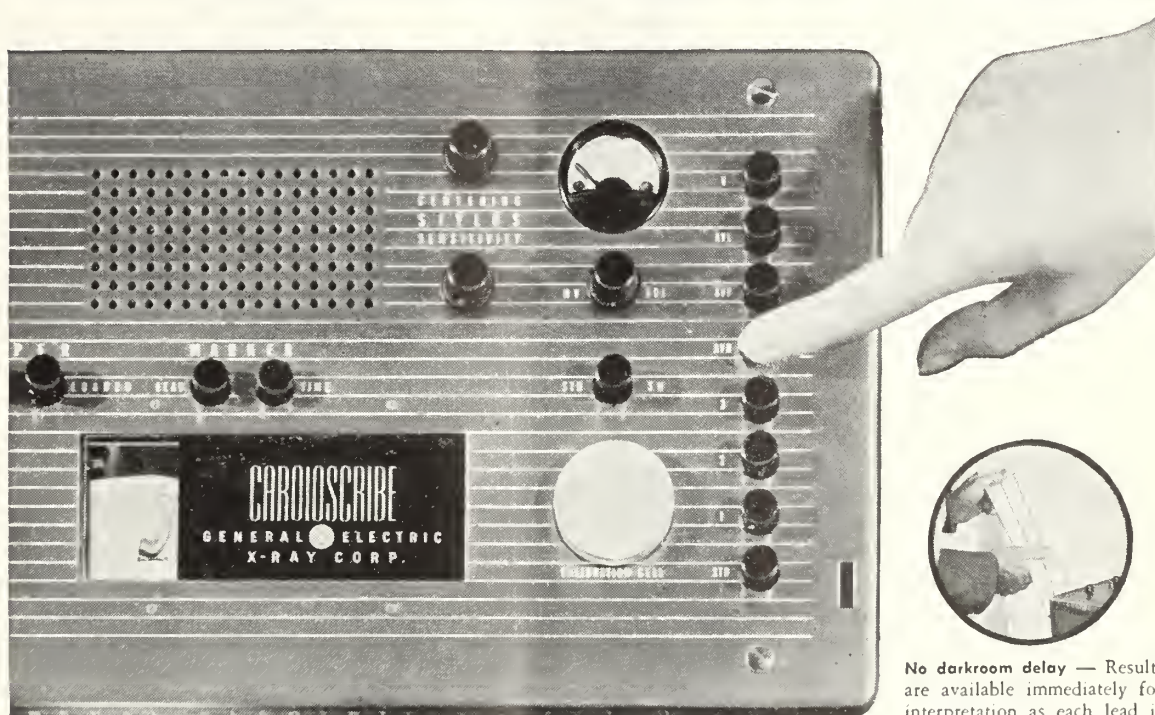
The national blood program of the American Red Cross has a variety of appeals and is becoming increasingly effective in Pennsylvania. A regional blood center will open at Wilkes-Barre on March 7 and will serve the territories of 27 Red Cross chapters in northeastern Pennsylvania. Our regional blood center at Johnstown has been serving a ten-county area and will be able to serve a much greater territory by the addition of a second bloodmobile unit and staff. The regional blood center at Philadelphia has gone far toward assuming the total blood needs of all the hospitals in this concentrated medical service area.

C. CLAYTON STREEVY,
State Relations Officer,
American Red Cross,
Harrisburg, Pa.

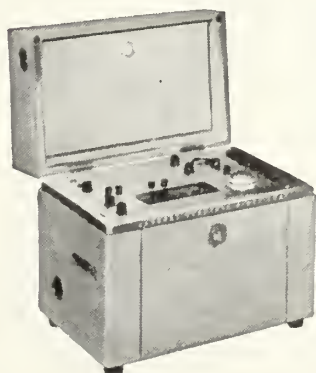
"The welfare state is just another version of the old feudal state . . . it is founded on a lack of faith in people." —JOHN MCPHERRIN, editor, *The American Druggist*.

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Look what you get with the
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- 7 push-button controls, make possible taking 17 separate leads, without regard to numerical sequence!
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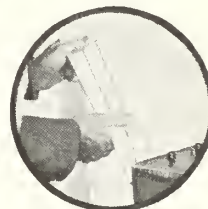
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No darkroom delay — Results are available immediately for interpretation as each lead is completed. No darkroom space, equipment or supplies required.



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CLINICAL observation and nutritional science agree that much depends upon the diet whether the individual will be biologically old at forty or biologically young at sixty.

To extend biologic youthfulness and vigor into later years, a good nutritional state based on an adequate diet is mandatory at all times. The efficient functioning of many physiologic processes is involved in maintaining good nutrition. On the other hand, only the adequate diet can sustain these processes. To assure such dietary adequacy under many conditions of physiologic stress encountered in day to day living, a properly organized food sup-

plement often assumes vital importance.

The *multiple-nutrient dietary food supplement* Ovaltine in milk richly provides many nutritional essentials when such supplementation is indicated. It provides excellent amounts of vitamins A and D, ascorbic acid, niacin, riboflavin and thiamine; the important minerals calcium, iron and phosphorus; and biologically complete protein. Its satisfying flavor and its easy digestibility make it widely useful in both general and special diets whether for children, adults, or the aged.

The wealth of nutrients presented by three glassfuls of Ovaltine in milk is shown in the table below.

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Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	676	VITAMIN A	3000 I.U.
PROTEIN	32 Gm.	VITAMIN B ₁	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



THE *Pennsylvania* MEDICAL JOURNAL

Volume 53

APRIL, 1950

Number 4

Practical Aspects of Nutrition in Surgical Patients

ROBERT M. ZOLLINGER, M.D., EDWIN H. ELLISON, M.D.,
and CLARKE T. CASE, M.D.

Columbus, Ohio

THE INFLUENCE of nutrition upon morbidity and mortality in various surgical disorders has gained almost universal recognition today. Physician and surgeon give close attention to the fluid, electrolyte, and vitamin requirements of their surgical patients. Yet there is still a tendency for them to entrust the actual selection of the type and quantity of food to nurses or hospital dietitians, or to members of the patient's family.

In 1939 Ravdin and associates¹ first called our attention to the necessity of protein replacement and the importance of an adequate caloric intake in correcting protein deficiencies in surgical patients. This thesis has withstood intensive laboratory and clinical investigations.^{2,3} In the light of this experience it behooves the modern surgeon to concern himself with accurate estimates of the protein and caloric needs of his patient and devote to them the same particular attention which he now gives fluids and electrolytes.

The calculation of caloric and protein needs assumes a major role in patients who have sustained a substantial loss in body weight, or who are suffering from a chronic depletion of protein

such as takes place in chronic sepsis, extensive burns, draining sinuses, and so on. If surgery is contemplated, sufficient time must be taken whenever possible for adequate nutritional replacement, if such postoperative complications as retarded wound healing, sepsis, malfunctioning anastomosis, and the like are to be kept at a minimum.

While the estimates for protein and total caloric requirements will vary according to the age and weight of the patient, as well as with the type and duration of the disease, it is possible to compute these needs rather easily. It may be assumed that the basic maintenance requirement for protein is approximately one-half gram per pound of body weight per day. Double this amount or 1 gram per pound is usually the goal during the preoperative and postoperative management of patients presenting problems of nutrition. The protein must be protected by an adequate number of additional calories, otherwise part of it will be burned for energy and thus lost for tissue replacement. Twenty calories per gram of protein should be supplied if possible, with a daily minimum of 1500 to 1800 total calories for the average patient. For example, the basic requirement of a 150 lb. man in good health would be calculated as follows: $150 \times \frac{1}{2}$ gram equals 75 grams of protein; 75×20 equals 1500, minimum caloric requirement. If the 150 lb. patient is a problem in nutrition, double

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these figures would be the daily goal, or 150 grams of protein and 3000 total calories.

Oral Replacement

Feeding by mouth should be utilized whenever possible since this method is the most effective and economical way of correcting nutritional deficiencies.^{4, 5} Familiarity with the protein and caloric values of the ordinary foods enables the physician to estimate easily the deficiency in any particular diet. Utilizing the formula previously presented, he can calculate the protein and caloric requirements and plan the diet according to the needs and individual idiosyncrasies of each patient. The majority of patients having elective surgery must wait a week or more before going into the hospital. The physician can profitably utilize this time by starting nutritional replacement at home. It is hardly sufficient to urge the patient to eat a large amount of cheese, cottage cheese, and other items commonly mentioned as high in protein. The physician must understand the approximate protein and caloric values of the staple items used by the ordinary family in everyday living such as milk, meat, potatoes, bread, butter, and eggs, both in evaluating the patient's current intake and in prescribing the necessary changes.

For example, the approximate values of the items to be remembered are as follows: 1 quart of milk contains 32 grams of protein and 670 calories; one serving of meat—18 grams of protein and 300 calories; one serving of potatoes—3 grams of protein and 128 calories; two slices of bread—5 grams of protein and 130 calories; one ordinary pat of butter—73 calories; and one egg—6 grams of protein and 80 calories.⁶

One must determine which of these common foods are acceptable to the patient, and how much he is able to consume daily. Although whole milk is one of the most important, economical, and complete foods available, many patients in the older age group may not tolerate it or refuse to drink it. Some people will accept milk if allowed to skim off the cream and add a flavoring agent. While skimming may decrease the total calories, it does not alter the amount of protein.

The diet can often be greatly enhanced by the prepared protein mixtures,^{7, 8} providing they are acceptable to the patient's taste and do not interfere appreciably with the general dietary intake. If these valuable materials are utilized, both phy-

sician and patient should know the protein and caloric contents as compared with common items of food. For example, a tablespoon of protolysate is equivalent to 6 grams of protein, the amount supplied by one egg. As much as a cupful or 15 tablespoonfuls of protolysate may be indicated to supplement the regular diet and insure a high protein intake. If the patient can tolerate this amount each day, the protein content will roughly equal that of three quarts of milk.

Progress should be followed by daily determinations of body weight. After entrance into the hospital the same attention to protein and caloric requirements must be continued, lest the patient be put on a routine "house diet" and lose some of the benefit previously gained. It may be necessary to continue the high protein, high caloric diet in the hospital for a number of days since it is advisable to delay major surgical procedures in malnourished patients until their daily weight curve shows a sustained upward trend.

Intravenous Supplementation

Augmentation of protein and calories by parenteral means has proved of value in those patients who are unable to take enough food by mouth. Furthermore, complete dependence on the oral route in the extremely malnourished individual, even when he is capable of taking a fair diet under strict hospital supervision, usually prolongs hospitalization if preparation is to be sufficient for extensive major surgery. In such instances we have utilized several liters of a parenteral protein hydrolysate (amigen) in dextrose solution to supplement the daily oral intake. Since such infusions may result in a diminished appetite, they are always given between meals, preferably after the noon and evening meal when the patient has already taken about two-thirds the amount of food ordinarily consumed.

The total volume of hydrolysate and the dextrose concentration must be varied to meet the requirements of the individual case. The combined oral and intravenous supplementation using 2 liters of 5 per cent amigen in 15 per cent dextrose often provides a daily intake approximating 4000 calories and 200 grams of protein.

Parenteral supplements of this type often suffice to convert a diet which merely supplies the ordinary daily requirement into one which actively restores the lost protein; an increase in circulating protein will be shown along with gain

in body weight, and the time needed for preparation for surgery may be materially shortened.

Intravenous Replacement

In a significant number of patients, the only practical method of protein and caloric replacement is by the intravenous route. Here, again, it is important for the physician to keep in mind the protein and caloric values of the materials commonly used. For example, 1 liter of blood supplies approximately 30 grams of protein, but only 120 calories, even if it should be utilized as food. Four units of plasma or 1 liter supplies approximately 60 grams of protein and 240 calories.⁹ While these sources of protein are invaluable, it is obvious that they in themselves do not supply an adequate amount of calories.

The traditional employment of 5 per cent glucose solution for all patients requiring intravenous alimentation provides only 200 calories per liter. While infusion of unlimited amounts of such a preparation may suffice to minimize glycogen depletion and forestall ketosis, it provides only a portion of the daily energy requirements. The ordinary patient can tolerate 10 per cent glucose solution with its doubled caloric value. Provided it is given slowly, a 15 per cent concentration of glucose can be utilized, affording 600 calories per liter. Complementing the daily caloric intake with higher concentrations of glucose spares appreciable amounts of body protein without administration of excessive fluid.

Complete feeding by the intravenous route came closer to realization with the development of the various protein hydrolysates.^{10, 11} The value of the higher concentrations of glucose as a source of calories cannot be overemphasized when using these preparations for protein replacement.^{2, 3, 12} One liter of a 5 per cent amigen and 5 per cent dextrose solution approximates 37½ grams of protein, but only 385 calories.

Clinical observations, combined with carefully controlled nitrogen balance studies in a series of patients, have convinced us that the utilization of protein given intravenously is related to the total calories administered simultaneously.¹³ While a constant protein intake was maintained, the daily caloric intake was supplemented with 5, 10, and 15 per cent dextrose. The positive nitrogen balance was practically doubled with each 5 per cent increase in the concentration of dextrose. Weight gains were confined to the periods of higher caloric intake.

The protolysates have proved most useful when given as part of a nutritional program planned for the specific demands of a particular patient. The amount of protolysate given will depend upon the size of the patient, the severity of the nutritional disturbance, and the goal, whether "maintenance alone" or "restitution" with weight gain.

Two liters of 5 per cent dextrose in 5 per cent amigen may be sufficient to prevent ketosis and minimize tissue protein breakdown in normal individuals over short periods of time. Experimental observations¹⁴ suggest that the remaining energy requirements are supplied by a breakdown of dispensable body fats. The average 70 kilogram patient, however, will lose weight on a program of simple protein maintenance.

The patient of average size may require 3 liters of 10 per cent dextrose in 5 per cent amigen for basal requirements. Such a régime supplies 113 grams of protein and 25 calories per kilogram and will maintain body weight, but cannot be expected to correct existing deficiencies.

In our experience, from 30 to 45 calories per kilogram of body weight must be assured if restitution of protein and weight gain are desired. Concentrations of glucose up to 20 per cent, depending upon the size of the patient, may be given. These higher concentrations can be utilized safely and efficiently if the infusion does not deliver more than 0.7 gram of dextrose per kilogram per hour.¹⁵ Glycosuria diuresis is commonly observed if this rate is exceeded, and calories are lost to the patient.

Reactions in the vein are minimized by a few simple precautions. Infusions are given by preference in the wrist or forearm. The use of small needles avoids occlusion of the vein, permitting a constant flow of blood past the point of injection. Prolonged use of a single vein is avoided.

It must be admitted that there are a number of undesirable features to prolonged intravenous alimentation. In the first place, it is tiresome, and at times painful; it may require immobilization up to eight or nine hours daily with the increased danger of intravenous thrombosis. Furthermore, intensive intravenous therapy is undesirable in a number of elderly, poor-risk patients because of the possibility of overloading an impaired cardiovascular system. In many instances the circulation is such that it is undesirable to give more than 1 liter of fluid per day.

Supplementary Tube Feeding

In the patient whose poor food intake is a result of impaired appetite without organic obstruction of the gastro-intestinal tract, it is often possible to introduce a nutritious mixture intermittently during the day by means of an inlying stomach tube and thus supply the needed quantities of fluid, protein, and calories.¹² It is well to start such feedings with homogenized milk, supplementing later with protolysate and dextrin as tolerance increases. Likewise, the use of the Abbott-Rawson tube for oro-jejunal feeding after gastrectomy is invaluable for "short term" nutritional replacement. Unfortunately, the oro-gastric or oro-jejunal tube feedings become disagreeable to the patient from irritation by the tube if it is left in place long enough to effect the desired nutritional replacement. Regurgitation of food with possible aspiration into the lungs adds further hazards to such a program in the elderly, debilitated, poor-risk patient.

Jejunostomy Feeding

In the patient for whom parenteral alimentation or oro-gastric feedings are inexpedient, a third method for maintaining nutrition is available in the jejunostomy. We have found an expanding field of usefulness for this procedure since an intensive investigation has resulted in a practical, inexpensive, economical, and well-tolerated jejunostomy feeding program.¹⁶

Although the use of jejunostomy for feeding purposes has had enthusiastic proponents in the past,^{17, 18} it has fallen out of favor in recent years and is now rarely utilized except in the presence of complete and possibly permanent obstruction of the upper part of the gastro-intestinal tract. There seem to be two chief reasons why jejunostomies have never enjoyed widespread popularity among surgeons. In the first place, most of the feeding mixtures advocated, while excellent from a nutritional point of view, too often cause diarrhea and abdominal cramps in the immediate postoperative period so that the patient often has been made sicker than he would have been without a jejunostomy. Second, the formulas of the jejunostomy mixtures have been complicated, expensive, and difficult to prepare; hence, impractical for ordinary use.^{19, 24} Lesser objections have been the addition of one more operative procedure and the possible dangers of intestinal ob-

struction due to fixation of the jejunum to the anterior abdominal wall.

Despite these admitted difficulties, it seemed that there were valid indications for wider use of jejunostomy if a satisfactory and efficient feeding mixture could be developed. With increasing experience, jejunostomy has proved useful in selected patients demonstrating severe caloric and protein deficiencies. It has been of value when oral replacement is drastically reduced or impossible in the presence of upper gastro-intestinal obstruction from cancer or ulcer. It has also been helpful immediately following upper gastro-intestinal surgery when sustained nutrition is important to avoid edema of the gastro-intestinal stoma and to decrease systemic complications. Occasionally it is of value in the presence of prolonged biliary drainage, especially in elderly patients who refuse to take an adequate diet. It is most helpful in cases in which prolonged intravenous therapy is undesirable. This includes aged patients with impairment of the cardiovascular system, patients susceptible to venous thrombosis in whom prolonged immobilization is undesirable, and patients whose caloric and protein deficiencies are so severe that intensive intravenous therapy for several weeks would be required.

We have preferred the Stamm type of jejunostomy, using two purse-string sutures of silk through which an open end No. 16 French catheter is introduced distally into the jejunum for a distance of 4 or 5 inches. The point selected for introducing the tube is as near the ligament of Treitz as is technically feasible (6 to 8 inches). If the jejunostomy is performed in pre-operative preparation for a subsequent resection of the stomach or esophagus, a short transverse incision is made in the left epigastrium just lateral to the left rectus muscle, and the tube is introduced at a more distal point in the jejunum in order to leave sufficient jejunum available for an anastomosis. The catheter is brought out through a separate stab wound. The jejunum is anchored with three or four interrupted silk sutures to the peritoneum about the opening for the catheter.

Stewart's criteria for an ideal jejunostomy feeding mixture²⁰ served as a guide for our research. These criteria are: (1) the mixture should contain an adequate amount of all nutritional elements; (2) it should be inexpensive and easy to prepare; (3) it should be easily

digested and absorbed with low residue; (4) it should drip easily by gravity; (5) it should be relatively stable in the refrigerator for 48 hours; and (6) it should not contain too high osmotic or salt concentration. Various recognized mixtures^{19, 21} were studied, including ordinary whole milk. While some patients tolerated these mixtures, the majority of them experienced difficulty if adequate amounts were administered during the early postoperative period. Although whole milk answers nearly all of Stewart's requirements, it was poorly tolerated by many patients. It was felt that the high fat content, about 40 grams per liter in commercial dairy milk, was the cause of the poor jejunal tolerance. Our collaborators in the Department of Physiological Chemistry pointed out that some investigators²² found that fat could be more easily absorbed if the particle size of the fat was reduced. It was decided to apply this observation to jejunal intolerance of regular milk.

The fat particles of whole milk average 4 microns, while fat particles of commercially prepared homogenized milk are $\frac{1}{2}$ to $\frac{3}{4}$ micron in diameter. Homogenized milk has the same amount of fat and calories per liter as ordinary milk, so it was substituted. Both in laboratory animals and in patients it was found that homogenized milk was well tolerated in all cases even when given within 24 hours of the construction of the jejunostomy. Homogenized milk has the practical advantages of being inexpensive, readily available, and almost complete nutritionally. It is high in calories (700 per liter) and relatively high in protein (35 grams per liter). By the second postoperative day most patients will tolerate as much as 2400 cc. of homogenized milk by jejunostomy, providing 84 grams of protein and a total of 1680 calories and rendering intravenous feeding superfluous. After a number of experiments utilizing varying concentrations of fat, carbohydrate, and protein with homogenized milk, the following feeding program has been developed:

The feeding is started by continuous gravity drip immediately after the completion of the jejunostomy and 5 per cent dextrose in distilled water is given at the rate of 50 cc. per hour during the day of operation. This routine has been used following major gastro-intestinal surgery in elderly cardiac patients as their only source of fluid with no intravenous fluids used postoper-

atively. On the first postoperative day homogenized milk is administered by gravity drip at the rate of 50 cc. per hour, providing a total of 1200 cc. and 840 calories. Additional distilled water and glucose may be added to this mixture to supplement the fluid and caloric requirements of the patient. By the second postoperative day the rate of flow by gravity drip is increased to 100 cc. per hour providing approximately 2400 cc. of milk, or $2\frac{1}{2}$ quarts, which equals 1750 calories. On the third postoperative day an Asepto syringe is substituted for the gravity drip and 200 cc. of homogenized milk is given every two hours along with 50 cc. of water to wash out the jejunostomy tube. By the third postoperative day this provides 3000 cc. of fluid, more than 80 grams of protein, and 1750 calories daily. This feeding program can be maintained for seven to ten days until the postoperative oral intake of the patient is built up to adequate levels.

It should be emphasized that considerable care must be exercised not to overload the intestine before there is evidence of peristalsis as shown by normal bowel sounds or by the passage of gas. Intestinal function may be aided by small enemas, rectal tube, suppositories, or 2 to 3 ounces of mineral oil introduced into the jejunostomy tube on the day of operation with repetition on the first and second postoperative days. If distention develops, the rate of administration of milk should be decreased until there is passage of gas or feces by rectum. In addition to supplying fluids and calories, early postoperative feeding has been shown experimentally to promote intestinal peristalsis and decrease the number of postoperative adhesions.²³

Further investigations were conducted to find the maximum concentrations tolerated by the jejunum in an effort to provide more calories and proteins for patients with long-standing nutritional deficiencies. The small intestine was found not to tolerate an excessive concentration of any constituent, whether fat, carbohydrate, or protein. The maximum concentration tolerated comfortably was one calorie per cubic centimeter. It was found that the best tolerated high caloric mixture was composed of commercial homogenized milk containing 4 per cent homogenized fat to which is added 5 per cent protein hydrolysate, and 6 per cent starch hydrolysate, a so-called 4-5-6 mixture.

These materials are not added until the patient is well regulated on homogenized milk alone. At the end of five to seven days 50 grams of protein hydrolysate per liter (roughly one-half measuring cup) and 30 grams of starch hydrolysate per liter is added to the basic homogenized milk formula (dexin, a starch hydrolysate containing 75 per cent dextrans and 25 per cent maltose was found to be best tolerated). If this is well tolerated for two days, the starch hydrolysate (dexin) is increased to 60 grams per liter, roughly one-half measuring cup, while the protein hydrolysate is maintained at 50 grams per liter. Ordinarily, one small can of the puréed liver utilized for baby food is added to increase the iron and vitamin content. Additional vitamins in the form of water-soluble ViSyneral in the amount of 0.6 cc. per liter may be added. When the patient is taking sufficient calories by mouth, the amount of material introduced into the jejunostomy tube is gradually decreased, since jejunal feedings will decrease the appetite of the patient. Furthermore, if jejunal feedings are pushed too hard throughout the night, the patient may be uncomfortable the following morning, and for that reason, unless it is especially desirable to build up the caloric intake, the feedings are discontinued between midnight and 6 a.m.

It is difficult for us not to be enthusiastic about the effect of jejunostomy and the simplified feeding mixture in a variety of patients presenting severe problems of nutrition. This is not to be interpreted as an advocacy of jejunostomy as a routine procedure. Its greatest indication is in those patients with weight loss of about 40 or 50 pounds in whom adequate oral replacement is impossible and in whom adequate intravenous replacement is difficult or impractical. We have used this procedure occasionally in poor-risk patients who had obstruction due to ulcer or cancer of the upper gastro-intestinal tract in order to improve their nutrition preliminary to an extensive resection. We have also found it useful in an occasional elderly, jaundiced, poor-risk patient who has refused to eat and whose cardiovascular status is precarious. Jejunostomy carried out at the time of cholecystectomy and common duct exploration greatly simplified the post-operative management of fluid, protein, and caloric intake. We believe that this procedure warrants wider use in poor-risk patients who present long-term problems in nutrition.

Summary

1. The same close attention should be given the caloric and protein needs of surgical patients now given routinely to fluid and electrolyte requirements. Calculation of the nutritional requirements is essential in any feeding program, whether it be oral, intravenous, or intubation directly into the intestine.
2. Poorly nourished patients should be given 1 gram of protein per pound of body weight. This figure multiplied by 20 indicates the total caloric intake which must be provided for the most efficient utilization of the protein supplied.
3. Oral replacement requires knowledge of the protein and caloric values of such common food items as milk, meat, eggs, and bread. Commercially prepared protein mixtures are only supplements to a general diet.
4. The place for concentrations of glucose to 10 or 15 per cent to be given simultaneously with protein hydrolysates is emphasized. The amount given depends on whether "basal" maintenance or restitution of protein and weight gain is the desired goal.
5. The major objections to the use of jejunostomy feedings have been corrected. A simplified, economical, and well-tolerated jejunal feeding mixture with homogenized milk as the base has been presented.

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ABANDON TERM "PREMEDICAL STUDENT"

At the recent American Conference of Academic Deans, serious charges were made against those responsible for medical education. Some of the remarks about their fellow educators were couched in language that must have shocked that presumably dignified and decorous gathering. Dean Simeon E. Leland, of Northwestern University, charged that the medical schools were using "Petrillo and Fishbein economics" in admitting students, implying that the profession was deliberately holding down the number of new admissions to its membership in its own selfish interest. "We need both more and better doctors" declared Dean Leland, as quoted in the *New York Times*. "If we had more, we would have better doctors. There would be more opportunity for medical research, and competition would weed out the weaker ones as it does in the other professions."

Dean William S. Guthrie, of Ohio State University, pointed out that in 1905 there were 160 medical schools in this country, graduating a total of 5606 students, whereas, in 1949, 79 medical schools graduated only 5094. He deplored the fact that "no matter how eligible, three-fourths of the applicants just can't get in" and urged a return to the accelerated program of the war years.

Dr. Joseph C. Hinsey, president of the Association of American Medical Colleges and dean of Cornell University Medical College, was quick to come to the defense of the medical schools in letters to the *Times* and the *Herald-Tribune*. He referred to Dr. Victor Johnson's figures, which indicate that there is at present an annual excess of medical graduates over deaths of physicians of about 2000, and pointed out that, since the beginning of World War II, seven new four-year medical schools have come into being in the United States and five others are in prospect or contemplated. Expansion of existing schools will further increase the annual increment of physicians.

The point of view of the deans appears to be that the medical schools should expand their facilities to take care of all qualified applicants, rather than in accordance with the need of the populace for medical care. Fortunately, there are countries in Europe that furnish

a demonstration of the effects of just such a policy. In Germany, in Austria, and in Italy there are medical schools with a thousand or more students in a class. All qualified observers, and indeed the faculties of these very schools, are agreed that the quality of medical teaching has suffered greatly as a result of such overcrowding. More serious still has been the overproduction of medical graduates in these countries since the war, for, contrary to Dean Leland's naive notion, cut-throat competition in an overmanned medical profession will not necessarily cause the best physicians to be the most successful. Such conditions generate impelling pressures to resort to unscrupulous practices for survival and lead inevitably to deterioration of ethical standards.

What is to be done about the 15,000 applicants who are denied admission to medical schools every year? Why does this represent such an appalling aggregate of frustration and broken hopes? It is largely due to the fact that in most colleges the student who is preparing for medicine is set apart and classified as such. Certain "premedical" courses are prescribed. He joins a "premedical" club. He identifies himself in his own mind and in the minds of his family and friends with a medical career long before he has demonstrated an aptitude for such a calling. When the door to medical school is not opened to him, after he has publicly committed himself to it, it is as if it had been slammed in his face. He is humiliated. He finds himself unprepared both psychologically and by virtue of his specialized preparation to accept any alternative.

College administrators could alleviate much of this distress if they abandoned the term "premedical student" and took pains to prepare every prospective medical student for an alternative career if medicine were not open to him.

They should realize that the larger interest of society would be best served by the gearing of the production of doctors to the demands for medical service rather than to the desires of candidates for medical schools.

If anything has been gained from this name calling, it has been to bring into focus more clearly than ever the pressing need for an impartial inquiry into the medical manpower requirements of the United States and how they are being met. —*The New England Journal of Medicine*, Feb. 23, 1950.

The Liver Biopsy in the Diagnosis of Liver Disease

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UNTIL recently the exact diagnosis of liver diseases offered difficulties due to the uncertainty and frequent inconsistencies of liver function tests. Liver biopsies, by means of a punch technique, have done much to clarify hepatic diagnosis and have become a widely used method of investigation. Although not the originators of a procedure that saw its beginning in 1895, Iversen and Roholm¹ in 1939 published their technique and the liver biopsy has become an accepted form of investigation. Under local anesthesia it is now possible to remove a segment of liver tissue 2 mm. in diameter and 2 to 3 centimeters in length. Sufficient tissue is thus provided for a microscopic study of the liver parenchyma. According to the preference of the investigator several biopsy techniques are available. In our clinic the transthoracic approach is preferred. We do not find it necessary to hospitalize the patient, most of our biopsies being done in the outpatient clinic.

As many investigators have adequately described the biopsy technique in detail,^{2, 3, 4, 5} our description will be brief. Preliminary medication such as morphine comforts the patient, but due to occasional nausea and vomiting it is not given to outpatients. We choose the last interspace on the right side on the anterior axillary line providing percussion dullness is present. After local skin sterilization the skin and deeper tissues down to the liver capsule are infiltrated with 1 per cent novocain. To facilitate the passage of the needle a small nick in the skin is made with a No. 11 Bard-Parker blade. We use a Vim-Silverman needle^{6, 7} with the stylet removed and replaced by a split cutting edge inner needle. After retracting the cutting edges back a little from the tip of the outer needle, both are introduced into the liver parenchyma. Holding the

outer needle the cutting edge is then advanced, engulfing a cylindrical piece of liver tissue. This cylinder of tissue is held between the prongs of the cutting needle by advancing the outer needle over the inner one. Both needles are given a full twist to break the point of liver attachment and are removed together. We have not found it necessary for the patient to hold his breath during the procedure.

The individual case is always considered carefully as to the advisability of biopsy, but there are two widely held contraindications to puncturing the liver—a prothrombin time elevated over 50 per cent of normal and massive ascites. A delayed prothrombin time can usually be corrected by the use of synthetic vitamin K, and the biopsy delayed until a more auspicious time. Mercurial diuretics and, if necessary, paracentesis will remove excessive fluid. Moderate ascites is not a contraindication. Chronic passive congestion was once feared, but usually can be ignored. Sherlock⁸ writes of 25 such cases done without untoward events.

Thousands of biopsies have been done in the past several years with progressively fewer fatal reports. Cogswell⁸ and co-workers report more than five hundred, generally by the transthoracic approach, without death. Lindert⁹ has had no fatalities in more than four hundred biopsies using the abdominal method. We have had no fatalities nor serious reactions in 170 cases. All but a few of our biopsies were done by the transthoracic approach, the majority in the outpatient clinic. After the biopsy the patient is kept on his right side for one hour and is permitted to return home. Right shoulder pain for 30 minutes afterwards is common and intercostal pain for as long as 48 hours is not unusual. Occasionally patients notice restricted ability to breath deeply for a day. Ordinary activities have rarely been restricted after the biopsy. One old alcoholic patient of ours has had seven biopsies

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* Died Dec. 6, 1949.

within the span of twelve months without any untoward event.

Unfortunately, sequelae to the liver biopsy procedure usually involve hemorrhage.¹⁰ A review of fatal hemorrhages reported by other investigators usually discloses severe situations such as advanced amyloid disease of the liver or multiple hemangiomas.² Those using the abdominal route report occasional cases of peritonitis^{4, 11, 12} due to puncturing the bowel or gallbladder. The absence of such complications when using the transthoracic approach lends argument for the chest route.

The glaring inconsistency of liver function tests is emphasized in severe "acute alcoholic" cirrhosis.^{13, 14} Several of our cases with normal liver function tests showed fatty vacuolization so severe that the cell nuclei were pushed to the periphery by the fat, giving a signet ring appearance to most of the parenchyma. It might be added that symptoms are frequently lacking in these same cases. It is in the "acute alcoholic" livers that improvement can be expected with a balanced high caloric diet. We have not seen extensive fatty replacement of liver cells in alcoholics who manage to eat with regularity. Indeed, Volwiler and Jones¹⁴ emphasizing food find no use for lipotropic agents or vitamins, confirming the old opinion that alcohol is usually not damaging to the liver when an adequate intake of food is maintained while drinking.¹⁵ Clearly the liver biopsy in cirrhosis offers some measurement of liver damage that is repairable.¹² That a severely scarred liver has little functional reserve is rational, but the reversibility of a fatty liver to healthy parenchyma is an often repeated observation. By serial biopsies, prognosis can be anticipated.

To the satisfaction of all doing liver biopsies there frequently comes some unusual diagnosis such as amyloidosis, lymphoblastoma, sarcoidosis, hemochromatosis, or unsuspected carcinoma, and liver biopsies have become an accepted diagnostic procedure if these diseases are suspected.^{2, 12} It is not suggested, however, that laboratory tests can substitute for a probing history and careful clinical findings.

In hepatomegaly, carcinoma always has to be considered. It is our custom when suspecting carcinoma to take three separate pieces of liver tissue. Using the same portal of entry in the skin we direct the needle in three different direc-

tions, thus securing tissue from three areas. In this way the chances of getting a carcinomatous nodule are increased threefold. Not uncommonly carcinoma is found in only one of the three pieces. Carcinoma of the stomach, pancreas, and colon notoriously metastasizes to the liver. The decision to operate frequently rests on the absence of evident metastasis. A liver biopsy in such cases is often justified and, if metastases are found, an unnecessary laparotomy can be avoided. Our series includes several cases of cancer in non-palpable livers, refuting the claims of some who hold that the biopsy should be reserved for enlarged livers.^{4, 11, 12}

Of paramount interest to most of us is the value of liver biopsies in differentiating obstructive jaundice from hepatitis. Within the first four weeks of jaundice, experienced pathologists are able with accuracy to detect the changes in liver parenchyma altered by virus infection and the changes due to back pressure of bile. The differentiation will be explained later in the paper.

The material on which the pathologic studies were made included four groups of cases: (1) 171 liver biopsies made on clinical cases at the Allegheny General Hospital; (2) a small group of needle biopsies made at autopsy and controlled by larger sections of liver taken at the same time; (3) ten surgical biopsies taken at operation in 1939 in connection with another problem; and (4) forty sets of liver sections taken from consecutive adult autopsies and studied as controls. Only the 171 needle biopsy group is shown in the table. The nature of the lesions was sometimes such that two or more were found in the same biopsy and listed separately so that the total diagnoses in the table do not equal the number of biopsies.

At the beginning of the studies it was apparent that liver biopsies presented a somewhat different problem than ordinary postmortem liver sections. In discussing Cogswell's paper,⁸ Popper emphasized the need for a new classification of acute hepatic damage which would facilitate the work. He added that biopsies might lead to a better correlation of functional tests with pathologic changes, aid the clinician to a correct diagnosis, and help the pathologist to learn more about liver disease. We heartily agree with this opinion.

TABLE OF LIVER BIOPSIES

	No. of Cases
Normals (revised standard)	54
Fatty metamorphosis (globular)	38
Capillary bile stasis	
including bile pools (3)	5
Acute infectious focal necrosis	2
Hepatitis	26
a. Epidemic (5 cases)	9
b. Alcoholic (subcirrhotic with fat)	7
c. Alcoholic (with alcoholic hyaline) ..	3
d. Periportal	7
Ascending infectious cholangitis	3
Chronic passive congestion (moderate)	5
Atrophic cirrhosis, with and without fat	13
Biliary cirrhosis	1
Eosinophilic infiltration	1
Tumors, primary?	3
Hepatomas	2
Bile duct	1
Tumors, secondary	18
Adenocarcinoma	6
Squamous carcinoma	9
Colloid carcinoma	1
Undifferentiated carcinoma	1
Multiple myeloma	1
Hemochromatosis	1
Primary amyloid disease (1 case)	1
Total	171

(We also had one case showing hemofuscin granules, but failed to find hemosiderosis, tuberculosis, sarcoidosis, or leukemia.)

In examining the postmortem liver sections, the pathologist has the organ before him or has a gross description of it. He can take as many sections as he wishes, use as many fixatives as he cares to, and do all the microchemical tests he chooses. He has been accustomed to making detailed descriptions and including minor changes, some of which may not actually be pathologic. The functions of the liver cells are many and we do not know how functional activity is reflected in the appearance of the cells, so that the first problem is to establish normal standards for liver biopsies. Mateer¹³ took the liver of a 10-year-old child as a theoretical normal and, measured by the usual criteria, found only 10 normals in 163 biopsies. Obviously such a standard is not practical. The biopsy is relatively small, only 1 to 3 cm. long and 2 mm. in diameter. It may not contain a single complete lobule. The objective in examining the slide also has changed, for the clinician is less likely to be interested in the academic question of protein particle size and intracellular pigment distribution than he is in

whether or not the biopsy shows hepatitis, cirrhosis, tumor, or something else that will help to explain the symptoms of his patient. Therefore, subject to future changes in criteria, we have decided to accept much less stringent standards of the normal than we have been using for autopsy specimens.

Arbitrary Standard for Normal Liver Biopsies

In our biopsy normals taken from patients with normal functional tests and no symptoms of liver disease, we have found that there is considerable variation in the size of the liver cells, in the size and staining qualities of the nuclei and the occasional occurrence of a mitotic figure. Most of the cells appeared slightly swollen and contained granules. Special stains brought out bilirubin, glycogen, and fat granules. We have included within normal limits small groups of leukocytes and mild periportal infiltration because they appear to be associated with extra-hepatic lesions, particularly gallbladder disease, gastric and duodenal ulcers. One of the more difficult changes to evaluate is granular degeneration or cloudy swelling. It occurs in biopsies otherwise apparently normal; it is constant in hepatitis during early cellular autolysis and in the repair of cirrhotic nodules. In postmortem livers it occurs after systemic poisons, administration of arsenicals, toxemias of pregnancy, severe nephritis, and even in postmortem degeneration. It is probably best considered as pathologic only when accompanied by other more specific changes.

Probable Significant Pathologic Changes

Fatty Metamorphosis. The large globular form of fatty metamorphosis may involve just a few cells or may be so extensive as to give the liver a honeycombed appearance. Globular fat is usually associated with abnormal metabolic states, obesity, and the overuse of alcohol. It is constantly present in the earlier stages of atrophic cirrhosis.

Pigment. In some biopsies, groups of liver cells contained coarse brown granules. These were taken to be bilirubin when they were gathered around the central veins and did not give microchemical reactions for other specific pigments. In one instance the granules gave a positive reaction for hemofuscin in the first and second biopsies, but the patient has not as yet shown

any other signs of hemochromatosis. There were several cases of brown atrophy which were considered normal because of the patients' ages.

Icterus. Bile stasis was diagnosed when the intercellular bile capillaries contained bile casts. Bile stasis may be local about secondary tumors or due to extrahepatic obstruction. In any case the larger bile ducts are likely to be empty, while many of the intercellular capillaries are packed with greenish-black bile resembling small twigs, often branched.

In three cases the bile pools mentioned by Cogswell et al.⁸ were present. These occurred in cases in which focal necrosis was associated with bile stasis and the largest ones were in a case of carcinoma of the head of the pancreas with obstruction. In a sharply defined area the liver cells had broken away from the supporting reticulum and assumed spheroidal forms. Some were shrunk and showed chromatolysis. The extruded bile, the separated cells, and the broken bile capillaries could be seen, but it was not possible to tell exactly from which capillaries the bile was coming. Bile pools and icteric casts aid in the diagnosis of obstructive jaundice.

Focal Necrosis. There were three types of focal necrosis. The first consisted of small areas sharply outlined and filled with cellular debris and segmented leukocytes. They were found in early hepatitis and in one case of duodenal ulcer. The second type was similar except that it contained mononuclear phagocytes. The third type appeared in the vicinity of periportal connective tissue in cases of periportal hepatitis and cirrhosis.

Hepatitis. Hepatitis occurred focally and diffusely. Focal hepatitis was found both in lobular and periportal areas. The epidemic form according to Dible et al.¹⁶ may be either peripheral or central but is generally diffuse and involves all regions. These authors state that the lesions are similar whatever the cause, whether virus, homologous serum, arsenical, or other agent. The changes are characterized by autolytic necrosis of liver cells and by an infiltration with leukocytes and reticular cells. The periportal types may occur as a part of the epidemic form or in suppurative cholangitis with destruction and repair of bile ducts.

Circulatory Changes. The circulatory changes of central necrosis and hemorrhage which are so

often mentioned in autopsy material were seldom seen in the biopsies, probably because liver biopsies are not often made on cases of cardiac decompensation or other heart conditions.

Cirrhosis. Cirrhosis was recognized in two forms in the biopsies—atrophic and biliary. Atrophic cirrhosis presents the same histopathologic changes as those seen in autopsy material. Practically all of the biopsies of cirrhosis showed an extensive infiltration with fat of the globular type constituting the so-called alcoholic cirrhosis. A helpful point in diagnosing cirrhosis of the atrophic type is that the margins of the lobules are usually rounded.

In the one case of biliary cirrhosis which we had the bile ducts and the periportal tissues were very much inflamed and the bile ducts were proliferating. The demarcation between the connective tissue and the remains of the liver lobules was not as sharp as that seen in atrophic cirrhosis.

Neoplasms. Tumors were divided into primary and secondary tumors. There were two hepatomas in the biopsy group. We were unable to determine whether they were actually malignant or merely reparatory since the tissue was too limited. There was probably one bile duct carcinoma, although we could not make certain of it.

Secondary cancers were simple to diagnose. We found 6 adenocarcinomas, 9 squamous cell carcinomas, 1 colloid and 1 undifferentiated carcinoma. There were no leukemias among our biopsies.

Cavernous Hemangioma. In one of the post-mortem liver biopsies there were a number of subcapsular cavernous hemangiomas. One was about 2 cm. in diameter on the anterior surface of the liver just beneath the capsule where it could easily have been reached by a biopsy needle. Had it been punctured, a severe hemorrhage might have occurred.

Conclusions

1. The liver biopsy is a rational and safe method of diagnosing liver disease, and may be either of positive or negative value.

2. The interpretation of liver biopsies is broadening the conception of the normal by accepting as within normal limits certain minor microscopic changes found in biopsies from persons

who have neither symptoms of hepatic disease nor abnormal functional tests.

3. Liver biopsies frequently clarify the causes of hepatomegaly not revealed by other diagnostic procedures, and have proved useful in establishing the diagnosis of early hemochromatosis, amyloidosis, and generalized granulomatosis, such as sarcoidosis and miliary tuberculosis, and in establishing the presence of primary or metastatic cancer.

4. They are useful in differentiating obstructive from non-obstructive jaundice and can be used to follow the progress of hepatitis and the prognosis of alcoholic cirrhosis.

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PRACTICAL A LA EWING

For many months almost all medical journals have carried much space and literally thousands of words on the subject of socialized medicine. In presenting this story the name of Oscar Ewing, that practical politician now sitting in complete charge of the Public Health Service in his post as Federal Security Administrator, is ever prominent. Could it be otherwise?

Very few editors noticed or bothered to comment upon his changing the name United States Public Health Service to the Public Health Service soon after he took over his position. This, in spite of the fact that it represents our second oldest commissioned service, being older than either the Army or the Navy. Only the United States Coast Guard, formed as the Revenue Cutter Service by Alexander Hamilton, can boast of prior origin.

We have noticed something very disturbing in recent months. Editors and medical writers (who really should know better) have lately fallen for that "birds of a feather" line and have occasionally turned their guns on the scientists, physicians, nurses, and other personnel of the Public Health Service. We are told that these people are closely linked with Oscar in plotting the downfall of American medicine. They are called medical bureaucrats and other less complimentary names, and since no word is raised in their defense, the barrage of misinformation continues with consequent confusion for the great American public.

We are happy to quote a very recent editorial from *Industrial Medicine and Surgery*:

"Are there good bureaucrats? On the door of one bureau at Bethesda, Maryland, a sign reads: 'Infectious Diseases.' Inside, the doctor in charge of polio research, Dr. Charles Armstrong, spent eight months in bed and nearly died from tularemia, and also came down with

dengue fever, parrot fever, Q fever, and encephalitis on other assignments. Another important research task force, under Dr. Leon Atlas, is exploring the common cold. He already has isolated the elusive virus which causes colds. Two other researchers, Dr. Charles Shepard and Dr. Robert Huebner, have made encouraging progress in the fight against Q fever—and, as usual, caught Q fever in the process. Doing field work in Texas, Dr. James Watt traced bacillary dysentery to flies and was able almost to eliminate it by fly control. Now he is continuing his experiments in another area near New Orleans. All research in the laboratory is under the general supervision of Dr. Karl Habel, who has been bedridden with Q fever and encephalitis, but is now searching for a potent rabies vaccine."

These men deserve unstinted praise. They are doing a wonderful work, for considerably less remuneration than could be theirs in private practice. Furthermore, since many of them live on government reservations, they are even deprived of their vote, yet they are fully expected to pay their full share of local city, county, and state taxes! Why call them "bureaucrats"? The mainspring of their interest isn't the fact that they are employees of the government. They do what they do because they are doctors!—*Current Medical Digest*.

Multiplicity of AMA Conferences

Because of the multiplicity of conferences, and also because most of the state secretaries and editors of state medical journals attend the Public Relations Conference, the AMA Board of Trustees voted to discontinue the Annual Conference of Secretaries of Constituent State Medical Associations and Editors of State Medical Journals.

EVALUATION OF PROSTATIC SURGERY

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THERE are several prerequisites for the author who will attack such a subject as the choice of operative procedure in prostatism. He must certainly be a veteran of thousands of encounters with the obstructed vesical neck, since experience alone will permit him, if he has an open mind, to formulate a clear surgical philosophy. He must also be one who is not completely satisfied with any given procedure no matter how skillful he may personally be with a specific technique. The urologist can scarcely be too lavish in his praise of those who are devoted to the principles of Fuller and Freyer, "the suprapubic school"; of Young and his followers, "the perineal school"; of Caulk and his followers, including Davis, Alcock, Milner, et al., "the transurethral school"; and of Millin and those other men who are devotees of the "retropubic technique."

An inherent part of the artistry of these superb technicians has been their ability to adapt any given patient to the technique they have individually perfected. These men have elevated each of these from techniques to the status of a standard procedure, but it must never be forgotten that because any given procedure can be applied by an expert to a wide range of cases it does not also follow that a particular technique is the best approach in all cases.

The middle ground is populated by those of us who have braved the perineum, mastered the ratchet and loop, approached the prostate from above, both from without and within the bladder. We are now championing the point of view that the patient is best served who has his operation best selected as well as best executed.

If there is any particular qualification on the senior author's part for discussing this matter, it may be that in an experience encompassing a

number of thousands of obstructive prostates he has approached them by all available routes. His early association with the late beloved Hugh Young certainly guaranteed an indoctrination with all of the virtues of the perineal approach. A survey of the results after a few years and following some striking disasters, particularly as to morbidity, made him conscious of the advantages in many cases of the older "suprapubic prostatectomy." Again, the long hospitalization with the higher mortality rates drove him enthusiastically into the field of transurethral resection. The possession of one of the earliest of the Wappler machines and a close friendship with McCarthy and Davis with their tremendous enthusiasm carried him into a prolonged phase of nearly 100 per cent resections over a long period of time. Again, a study of morbidity rates impressed him with the fact that resection in all cases was not the proper answer to the problem. The subsequent acquisition of two young associates with enthusiastic investigative minds has since led to considerable experience with primary closure after suprapubic enucleations, and his personal friendship with Terence Millin, plus the opportunity of a personal introduction to the technique, has given us profound respect for the virtues of the retropubic route. The morbidity and mortality of recent years are, of course, not to be compared with our earlier figures due to the use of the antibiotics and chemotherapy.

In our clinic today we feel competent to operate electively by any one of the four routes and with modifications of techniques in all surgical approaches. We believe that we have passed beyond the stage of simple acquisition of technical familiarity with the several procedures; that each individual case is considered on its merits, and that the operative procedure selected is that which, in our opinion, offers the patient the safest, most complete eradication of his difficulties. Let us then attempt to establish our criteria.

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.

From the Department of Urology, St. Vincent's Hospital.

Benign Hypertrophy and Malignancy of the Prostate: Obviously it is of primary importance to establish a diagnosis of benign hypertrophy of the prostate. Until some reliable test for malignancy preoperatively is devised—and Huggins may yet give us such a test as a result of his research—the diagnosis of benignancy is made by default. In the absence of a stony induration on rectal palpation, with no evidence of demonstrable metastasis, and in the absence of an elevated serum acid phosphatase, we consider the enlargement benign. When the problem before us is that of managing the malignant obstructive prostate with local extension or distant metastasis, we feel that the transurethral route has certain advantages. The chance of the necessity for repeated operations is great, and "repeat resections" are far less of a problem than "repeat" open operations. Usually we resort to surgery of any kind only after endocrine therapy has proved inadequate for our purposes. It must be clearly understood that endoscopic resection for benign hypertrophy is one operation and resection for otherwise inoperable carcinoma is a completely different procedure. The results in terms of mortality and morbidity are not comparable and may lead to considerable statistical confusion.

One must not place unwavering faith in the rectal examination. Too often a gland considered benign preoperatively has been viciously malignant under the microscope and vice versa, but it is at present our most reliable guide. If an early carcinoma of the prostate is suspected, then we are discussing something else besides the treatment of hypertrophy. We believe emphatically that an early carcinomatous nodule in the prostate calls for the perineal approach, biopsy, and if confirmation of our suspicions follows, this is the one indication for radical total perineal prostatectomy. In our clinic, if we finally satisfy ourselves that there is little likelihood of an eradicable carcinoma, we dismiss the thought of perineal approach. However, we believe that it is our duty to teach our resident staff the classical conservative perineal prostatectomy.

Size and Configuration of the Gland: Rectal palpation, x-ray visualization, and cystoscopic survey are the methods of gaining information as to the size of the obstructing adenoma and as to whether it is intra- or extravescical. If the urine of the patient is sterile, we often operate without instrumentation, waiting to appraise the situa-

tion at the time of operation. The huge intravesical prostate can be attacked transurethrally, perineally, or retropubically, but the suprapubic approach seems to us to offer operative ease with a short anesthesia and the least trauma to important structures. On the other hand, the ball-valve median lobe, the median bar, and the sclerotic bladder neck can be so completely excised by the resectoscope, without disturbance to the non-adenomatous remaining prostate and with such little risk to sexual potency, that we unhesitatingly choose the transurethral approach for these cases.

In general, unless other factors must be considered, glands which do not come within the above categories may be approached by the retropubic technique. It is very rare for us to resect more than 30 grams of prostatic tissue since adenomas of larger size are selected for some open operative approach.

Status of the Bladder: Papillomas, carcinomas, multiple or large calculi, resectable diverticula, and lesions of questionable character within the bladder demand an approach which permits the surgical attack upon both the vesical neck obstruction and the complicating pathology. Usually this means the suprapubic transvesical operation. Badly infected bladders may have to be drained suprapubically for long periods of time before the enucleation can safely be performed. The rationale of a suprapubic drainage followed by a perineal prostatectomy as advocated by some men does not appeal to us. Why open up more avenues of possible infection when the bladder is already opened?

The Urethra: The greatest cause of postoperative morbidity following transurethral resection has been injury to the urethra by the manipulation of the resectoscopic sheath. This factor caused Nesbit to incise the urethra in the bulbous portion and insert the resectoscope through this incision in the perineum. Lubricants, meatotomy, perineal urethrotomy, the postoperative use of silverized catheters, while helpful, have not eliminated this complication. A small caliber urethra or a previous stricture is considered a definite indication for open surgery.

Age of the Patient: The so-called young prostatic (50 to 60), other things being equal, is apt to live long enough to develop new obstructive adenomas. This is especially true if any ade-

nomatous tissue is allowed to remain. The relative youth and good physical condition of the patient make thorough enucleation by open operation the approach of choice, and in our experience sexual potency has been as well preserved after retropubic prostatectomy as after transurethral resection. The most accomplished resectionist often fails to remove all of the adenoma even though the obstruction is relieved for long periods of time. We have done too many repeat operations on our own cases as well as on those of other urologic surgeons to think otherwise.

Elderly patients, 80 plus, are by the same reasoning less liable to live long enough to have troublesome recurrences after resection, so that this is not considered to be of importance in the selection of resection as opposed to open operation.

Accessory Factors: There is always a diversity of non-urologic conditions which must be considered as contraindications to any given procedure. Occasionally the patient crippled with arthritis cannot be placed in position to do several of the necessary procedures. Colostomies as well as the residual scarring of former abdominal vesical surgery may cause one to ignore the abdominal approach. Previous urologic surgery also modifies one's selective judgment. Previous transurethral or suprapubic attacks preclude an attempt to do retropubic prostatectomies with anything approaching ease. In a scientific appraisal of this whole subject we should not be swayed by the patient who demands "one of those electrical operations where you don't have to make any incision" any more than we should be swayed by the referring physician who says "and don't send me back another one of those pseudo-surgical resections—take this one out." However, these indications are difficult to ignore. If the situation is thoroughly explained to the average patient and the referring physician, there is little difficulty in getting both to permit the operation which will best serve the patient as to both morbidity and mortality.

Morbidity and Mortality: In our clinic we fear morbidity more than we do mortality. Quite frequently the general and/or the urologic condition of the patient is such that all surgery seems contraindicated. In these cases the facts should be placed before the patient and the surgeon should abide more or less by the patient's decision. The urologic surgeon is quite frequent-

ly justified in doing a fast radical operation, facing the mortality, to give the patient who so desires a chance, remote though it may be for operative survival. Striking examples could be quoted in men of 80 plus, in very poor general condition, whose expectancy at the most would be a couple of years, who have survived open complete retropubic and suprapubic prostatectomies with subsequent long periods of comfortable life. In these cases we must not be fearful of our statistics. Some men argue for the transurethral procedure in these cases as the safest, but our experience is that this statement is not altogether true. Our figures consistently show that the mortality is about the same regardless of the surgical approach even under choice conditions, and certainly no one can argue against the fact that the morbidity rates are higher after the transurethral operation. Suffice it to say that in the hands of many operators equally skilled the difference in our mortality figures will hardly be worth considering.

In an effort to offer a practical application of our thinking at the moment, Dr. Dorman, our chief resident, has summarized the prostatic work in the clinic for the year 1948. This represents the work done by at least four different men including our chief resident. Therefore, it is a cross-section of the work of men of varied surgical training and experience, working together in a resident-training program.

I. All told there were 142 prostatic operations in the series. Of these, 61 or 43 per cent were done transurethrally; 54 or 38 per cent retropubically; 27 or 19 per cent, suprapubically, and none perineally. There were 5 deaths, or 3.5 per cent mortality.

II. Complications.

A. Incontinence.

1. Transurethral: One case which was malignant had been on stilbestrol for six months prior to operation and died five weeks after discharge from the hospital.
2. Retropubic: None. (It may be parenthetically added that one patient was incontinent for a period of five days after the removal of the retention catheter. A second patient had an atonic bladder with a large diverticulum and a left hydro-nephrosis secondary to the prostatic hypertrophy. This patient stated that he did not realize when it was necessary for him to void. A third patient was continent during the day, but instead of asking for

a urinal at night or reaching for one, he would merely take the easiest way out.)

3. Suprapubic: None.

III. Blood loss: We have made no determinations of actual blood loss per operation as has Dr. Goldstein. Clinical judgment is used as to need of replacement, and our patients are not routinely transfused. Thus our replacement may be used as a rough guide as to loss of blood.

1. Transurethral: Two patients were given transfusions. One required 3 pints.
2. Retropubic: Nine patients required transfusion and 3 required 2 pints. One of these patients had pernicious anemia and a low count on admission.
3. Suprapubic: Eight patients required transfusion. One patient had a secondary hemorrhage six days postoperatively requiring reopening and packing the fossa with oxyeel.

IV. Epididymitis.

1. Transurethral: Three cases. One patient was admitted with an epididymitis.
2. Retropubic: Three cases. One patient did not have vasectomy. One patient had had the vas tied a year before, at which time he had had a transurethral resection; they were not re-ligated.
3. Suprapubic: Three cases.

(This is a total of 9 cases with epididymitis, or 6.3 per cent. However, we have since modified our technique and now do a complete resection of a small portion of each vas and hope to reduce this complication.)

V. Mortality.

1. Transurethral: Two deaths. One patient died the third postoperative day of a cerebral accident. The other death was due to oliguria, believed to be the result of intravascular hemolysis. This was a 57-year-old man in good condition preoperatively but who developed oliguria postoperatively and died in uremia 13 days after operation.
2. Retropubic: Two deaths. One patient died 11 days postoperatively of bronchopneumonia, and the other died 17 days postoperatively of renal failure and bronchopneumonia. The latter had a blood urea nitrogen stabilized at 20, and the gland removed weighed 130 grams.
3. Suprapubic: One death. This patient bled

continually postoperatively because of a blood dyscrasia and died six days postoperatively despite all attempts to control bleeding.

Total mortality: 3.6 per cent.

VI. Diabetes.

It is interesting to note that 11 or 7.7 per cent patients had associated diabetes.

VII. Thrombophlebitis.

1. Transurethral: None.
2. Retropubic: None.
3. Suprapubic: One case.

VIII. Osteitis pubis.

1. Transurethral: None.
2. Retropubic: None.
3. Suprapubic: None.

IX. Stricture formation.

1. Transurethral: Stricture formation is quite common following a transurethral prostatectomy. Stricture is sometimes located at the anterior meatus, but more frequently is seen at the bladder neck. Sounds are routinely passed in these cases at monthly intervals for a period of three to five months.
2. Retropubic: This has been observed in only one patient who had a total prostatectomy performed because of malignancy.
3. Suprapubic: Postoperative stricture is rarely seen following this procedure.

X. Potency: This is a difficult thing to evaluate, but we can make the following negative statement: We have had less men complaining of impotency following transurethral and retropubic prostatectomy than from either of the other types, although this we do not consider too important.

Conclusions

1. We hope that we have demonstrated by this report that prostatic pathology requiring surgical treatment also requires the specific operative procedure that will best fit all the needs of the patient.

2. We are attempting, in our resident-training program, to so indoctrinate the young men for whose urologic training we are responsible.

The Management of Spinal Anesthesia

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IN CONSIDERING anesthesia for a patient, the surgeon must view the patient's physical status and proposed operation in relation to the advantages and disadvantages of the anesthetic choice. He must decide which of the anesthesia procedures either singly or balanced will facilitate the operation and at the same time produce minimal disturbances in the patient's physiologic activity. The proper selection and, more particularly, the proper management of the anesthesia will do much to facilitate the operation and, more importantly, reduce morbidity and mortality in the postoperative period. The practice of routinely using a certain anesthesia procedure for certain operations without regard to the patient's physical status is unscientific and should be condemned.

If the operative procedure is in the abdomen or on the lower extremities, it might fall into the realm of spinal anesthesia. It is the management of this procedure that I wish to discuss.

Early enthusiasm for this form of anesthesia led to its indiscriminate use. This resulted in many poor results and complications and much dissatisfaction on the part of both patients and surgeons. Some of this dissatisfaction has resulted from the lack of versatility of the spinal anesthetist as well as a lack of appreciation of the dual innervation by the somatic and autonomic nervous systems to topographic areas of the body.

The field of surgery has broadened to include unusual and lengthy operations in bizarre positions, so that spinal anesthesia administered in its simplest form is often inadequate or dangerous. If unusual or abnormal positions are necessary but contribute to the danger or inadequacy of the anesthesia, one can often surmount these difficulties by employing one of the more complicated spinal techniques.

In considering spinal anesthesia for a patient, the surgeon should think of its adverse physiologic effects rather than its advantages. These need not turn one away from spinal anesthesia in all cases, for many of them can be overcome by the administration of drugs and by fitting the type of spinal anesthesia to the position the patient will be in during the operation. One should be familiar with all of the accepted drugs used for spinal anesthesia and should be able to produce spinal anesthesia by the single and fractional techniques, using hyperbaric, isobaric, and hypobaric solutions.

Indications and Contraindications

Spinal anesthesia may be used for all operations below the diaphragm where there are no clear-cut contraindications to it. No other anesthesia will afford the surgeon a more ideal field in which to work. Under these ideal operating conditions there is minimal blood loss and trauma to surrounding structures. These factors tend to limit postoperative morbidity and mortality. It must be remembered at this time of enthusiasm that the prime factor influencing the anesthetic choice is the patient's physiologic state and not the operation or the surgeon's desire for ideal operative conditions. At times he must be willing to accept less than ideal operating conditions in the interest of the patient's safety and welfare.

In addition to the indications for spinal anesthesia on a basis of the location of the operation, there are several more direct and positive indications for this choice. Patients with diabetes, pulmonary disease, severe liver and/or kidney disease should generally have spinal anesthesia. The anesthetic will not tend to injure or exacerbate the patient's associated pathologic condition. It is true that among this group you will find some of the contraindications to spinal anesthesia, but the contraindications are mostly relative. Often the adverse physiologic effects of spinal anesthesia, mainly in the cardiovascular

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system, may be overcome or minimized by minimal spinal anesthesia combined with a light general anesthesia and use of supportive measures.

The use of high¹ spinal anesthesia on patients with severe emphysema or asthma is accompanied by much danger. Middle and low levels of spinal anesthesia can be used in these cases with relative safety. Atelectasis tends to occur more frequently in cases with respiratory system disease. However, the use, postoperatively, of vigorous respiratory "stir up regimens" with close attention to removal of pulmonary secretions, by tracheal aspiration, if necessary, will nearly eliminate the occurrence of severe postoperative respiratory complications. If this meticulous postoperative care is available, this objection becomes less important.

The contraindications to spinal anesthesia are absolute and relative. The absolute contraindications are pyoderma of the puncture area and inability to perform spinal puncture because of deformity or osseous barriers. The presence of diseases of the nervous system, bacteremia, active syphilis, and virus diseases are relative contraindications which become absolute in the light of medicolegal implications.

Relative contraindications are hypotension, hypertension, marked anemia, severe hemorrhage, actual or incipient shock, gross obesity, and severe coronary disease. These may be absolute contraindications to high levels of spinal anesthesia, but do not necessarily contraindicate mid and low levels. They may not be contraindications if combined methods are used and if measures for maintenance of blood pressure, hyperoxygenation, and compensation for blood loss by immediate and concurrent transfusion are employed.

Children and mentally or emotionally disturbed patients are not ideal subjects for spinal anesthesia. If spinal anesthesia is indicated, it can be accomplished by producing a light general anesthesia, preferably with pentothal, before or immediately after performing the spinal puncture. This type of combined or balanced anesthesia can be fraught with danger and should be attempted only by those thoroughly skilled in the use of spinal anesthesia. The main objection of many patients to spinal anesthesia is that they are awake and aware of the operating room. This objection is usually overcome if they are

assured that they will be asleep throughout the procedure.

Adverse Physiologic Effects and Complications

The primary adverse effect is marked drop in blood pressure. This has been said to be due to:

1. Loss of vasomotor tone with pooling of blood following block of the sympathetics.
2. Reduction of muscle tonic effect in extremity vessels due to motor paralysis.
3. Inadequate venous return from trunk and lower extremities due to motor paralysis of thoraco-abdominal muscles.
4. Inhibition of cardiac output due to high spinal block of the cardiac sympathetic accelerators.

Any or all of these factors can contribute to a drop in blood pressure, but it would appear that loss of vasomotor tone and pooling of blood in the area of sympathetic block is the most important factor. The work on differential spinal block by Sarnoff and Arrowood,² using dilute concentrations of procaine to produce sympathetic and pain fiber block without clinical effect on nerve fibers concerned with touch, temperature, and motor function, lends support to this concept. They have demonstrated that the degree of blood pressure reduction is proportional to the number of sympathetic segments blocked. The extent of the block of sympathetic outflow from the spinal cord is always many segments higher than the level of sensory and motor anesthesia. This factor is extremely important in anticipating the degree of blood pressure reduction for the various levels of spinal anesthesia.

The drop in blood pressure is at times terrifying, particularly in the older patients. If preliminary sympathomimetic drugs have been used, this adverse effect is usually lessened. These drugs must be given before the injection of the spinal anesthetic so that absorption and systemic effect precede or coincide with loss of vasomotor tone. At times it would be expedient to administer them intravenously in small intermittent doses or in continuous dilute concentrations.

Numerous drugs have been advocated for support of blood pressure in spinal anesthesia, and many are at present being investigated. Ephedrine is most widely used, but *d*-desoxyephedrine (methedrine) and neosynephrin have their staunch advocates. All seem to give good pharmacologic effect on the original dose, but

neosynephrin is more effective on subsequent doses. It has been used very effectively in continuous dilute concentrations as advocated by Thomas.³

Hypotension should be quickly corrected or prevented because of its immediate stagnant anoxic effect. This hypotension and stagnant anoxic effect can be the cause of remote complications. In a patient with coronary or myocardial disease sufficient myocardial damage may develop from stagnant anoxia to cause decompensation several days postoperatively. Stagnation of circulation may lead to a phlebotrombotic phenomenon, particularly in the cerebral vessels. Anuria has occurred following periods of sustained low blood pressure.

Another adverse effect is diminution of respiratory exchange due to high blocking of the intercostal muscles deliberately or inadvertently. Hypopnea may also follow excessive premedication or overdose of complementary combined general anesthesia. Rarely respiratory arrest may occur if the anesthetic migrates to include the fourth cervical roots, thereby paralyzing all intercostals and the diaphragm. In the latter case it is necessary to institute immediate and adequate artificial respiration with oxygen until the effect of the anesthetic has regressed. This is efficiently done by intermittent positive pressure on the breathing bag of an anesthetic machine. The lack of equipment to give artificial respiration with oxygen is sometimes listed as a contraindication to spinal anesthesia.

If the problem is only one of reduced respiratory exchange, oxygen should be given by mask or nasal catheter. This is a good procedure to follow with all high spinals and some mid-spinal anesthetics. Hyperoxygenation of the blood by inhalation of 100 per cent oxygen should be accomplished during periods of reduced blood pressure to compensate for stagnant anoxia during this period.

The occurrence of nausea and retching is distressing to both patient and surgeon. It can easily be overcome by a light general anesthesia either with intravenous pentothal or inhalation of cyclopropane.

The remote neuropathic complications of meningitis, meningismus, radiculitis with partial or complete paralysis, abducens paralysis, and cauda equina syndrome affecting the sphincters of bowel and bladder do occur. Their frequency is

not great and tend to occur in the hands of the casual spinal anesthetist. Mostly they tend to remit and are rarely fatal. They are probably no more frequent than death or serious complication incident to aspiration of vomitus or the effects of deep general anesthesia.

The most frequent and probably the most distressing postanesthetic complication is headache. This occurs in all degrees but rarely in severe form. Its incidence is variously given as 5 to 25 per cent. It has been demonstrated by Tuohy and others that there is a large psychic element in the occurrence of postspinal headache. It occurs more frequently in those with emotional and vasomotor instability. I have never regarded headache as a severe complication, for it is self-limiting and can be greatly helped by sedatives, intravenous or intramuscular injections of nicotinamide, and glucose intravenously. These patients have a spinal hypotension and recently Hingson⁴ has suggested serial epidural injections of saline into the caudal canal to cause epidural pressure and indirectly increase the intraspinal pressure. The use of tight abdominal binders to increase lumbar and splanchnic area venous pressure and indirectly raise spinal fluid tension is being investigated. Headache should be regarded as a small price to pay for the safety of spinal anesthesia under most circumstances.

Technical Consideration

Before considering spinal anesthesia for a patient, the anesthetist should be thoroughly familiar with what happens to the drug when it is injected into the dural canal. The factors which control the extent of anesthesia are: (1) site of injection, (2) volume of solution, (3) amount of the drug, (4) force of injection, (5) position of patient at the time and within the next ten minutes, (6) specific gravity of the dissolved drug or mixture. All are of importance, but specific gravity of the mixture in relation to position of the patient is the major factor influencing success, failure, or immediate untoward results.

In selecting a technique one should generously estimate the duration of the operative procedure as well as the position of the patient throughout. Where the operation will outlast the normal duration of a single injection or the time of duration is not known, one of the continuous fractional techniques should be used. The Lemmon⁵ needle technique and Tuohy⁶ catheter technique

both have their virtues, but in most circumstances I¹² prefer the catheter technique because of its greater flexibility.

The use of sympathomimetic drugs mixed with the anesthetic drug has been suggested by Whitacre,⁷ Romberger,⁸ and others. The use of vasopressors within the spinal canal has prolonged the duration of the presently accepted spinal drugs while permitting reduction in the total dose. There appears to be no systemic effect of these intrathecally administered drugs. The occurrence of neuropathies is neither different nor more frequent.

For operations on the abdomen or extremities where the patient will be supine and flat or tilted head down less than 10 degrees, I prefer pontocaine hydrochloride and glucose by the Sise⁹ technique or pontocaine, glucose, and ephedrine as advocated by Whitacre.⁷ Dosage and position of the patient are varied to assure extent of anesthesia to the correct level. If operation is apt to be longer than 90 minutes, the indwelling catheter technique is employed and .3 per cent pontocaine hydrochloride in equal amounts of 10 per cent glucose and spinal fluid is used. The original dose is usually 5 to 7 mg. and additional amounts of 3 mg. are injected hourly or as necessary.

It is possible to produce the segmental type of anesthesia using the catheter technique, hypobaric solution, and Trendelenberg position before injection is made. The anesthetic migrates cephalward and blocks the correct thoracic segments without producing motor paralysis in the lumbar and sacral dermatomes. This is a modification of the segmental type of spinal anesthesia advocated by Saklad.¹⁰ This maintenance of extremity muscle tone appears to somewhat prevent marked reduction in blood pressure. It may be the Trendelenberg position which really maintains the blood pressure in this situation. Hypobaric solution of .1 per cent pontocaine hydrochloride can be used with the catheter technique if lighter than spinal fluid mixtures are indicated.

Where surgery involves both abdomen and perineum, one must be careful that segmental anesthesia is not produced inadvertently by the catheter technique. In these cases it is necessary to vary the position of the patient immediately after the injection to assure migration of the anesthetic into the correct areas of the dural canal to involve the nerves to the perineum as well as to the abdomen.

If hysterectomy is to be done under spinal anesthesia, the Trendelenberg position should be limited to 10 degrees and this factor should be used in calculating the dose of the drug given. If deeper degrees of Trendelenberg are to be used, one should maintain the patient flat for at least 15 minutes to allow for fixation of pontocaine-glucose mixtures. Occasionally cases of late fixation of the drug will be encountered. The late cephalic migration of the drug incident to deep Trendelenberg position will result in dangerously high levels of motor paralysis. The addition of sympathomimetic drugs to the spinal mixture increases the time necessary for fixation. Hypobaric solutions of pontocaine hydrochloride are extremely useful in this type of surgery since they migrate caudally rather than cephalward when the patient is in the Trendelenberg position.

For operations in the prone or lateral positions, hypobaric solutions of .1 per cent pontocaine hydrochloride with or without vasopressor drugs are valuable. The patient can be placed in the position of operation and, because of the tendency of hypobaric solution to migrate upwards, a high index of sensory anesthesia with minimal motor paralysis is possible in the prone position. In the lateral position a predominantly unilateral anesthesia can be produced. The administration of the anesthetic in the elected position for operation obviates the necessity of moving and lifting the patient from the position necessary for spinal puncture and subsequent position for proper migration of the anesthetic into the final position for operation. The changing of the patient's position back and forth or from one table or carriage to the operating table is frequently accompanied by marked reductions in blood pressure.

The use of the sublamina approach¹² to the spinal canal from a point 1.5 cm. to the right or left of the mid-line greatly facilitates spinal puncture in the prone position. Where mid-line spinal puncture is difficult or impossible because of osteo-arthritis of the spine, or where the ideal spinal puncture position cannot be achieved because of casts, obesity, or limitation of hip motion, the lateral sublamina approach will almost always result in a successful puncture. This approach would seem to be less traumatic since the needle traverses skin, muscle, and ligamentum flavum instead of the dense supraspinous and intraspinal ligaments.

Regardless of which drug and technique is selected, the minute-to-minute management of the patient immediately after the injection of the spinal anesthetic is by far the most important factor in safe and satisfactory anesthesia. As soon as the injection has been made, the spinal anesthetist should participate actively and without delay in positioning of the patient and the table. The forces which determine the final extent of the anesthesia begin at once. The anesthetist should, insofar as possible, be in control of these forces and not at their mercy. What is done about position of the table and patient in the first few minutes will result in superior or inferior anesthesia in the over-all picture.

As the anesthesia migrates there is a progressive loss of vasomotor tone. The rapidity with which this can occur coincides with the onset of anesthesia and is a matter of minutes. If sympathomimetic drugs have been given previously and are systemically active, they prevent, by their peripheral action, most of the effects of central loss of vasopressure.

While the anesthetist is modifying the anesthetic's migration, he must also be observing the condition of the circulation from minute to minute. If undue reduction in blood pressure has occurred, this may be supported by additional vasopressor drugs given intravenously. Failure to observe falling blood pressure or to disregard its danger may result in depression of the brain centers of respiration and vasomotion with continuing deterioration of the patient downward until death. The initial reduction of blood pressure is sometimes precipitous. Usually it rises after the initial drop, but in some circumstances those minutes of low blood pressure may place a patient in an irreversible vascular collapse.

It is expedient to have facilities previously prepared for prompt and accurate venipuncture within two minutes after injection of the drug. One should determine before injecting the anesthetic that easy venipuncture is possible. In the event that veins are inaccessible or difficult to find, intravenous infusion should be started prior to anesthesia either following diligent search of the extremities or by surgical exposure of an available vein in the ankle. The presence of a freely dropping intravenous infusion is an avenue for the prompt administration of vasopressors into the tubing. If necessary, plasma, blood, or pentothal can be administered by this already

established route. It should be regarded as a life line.

The first seven minutes after the injection of the anesthetic are busy ones. The spinal anesthetist should be doing several things at the same time. He may at times require the assistance of other personnel in the operating room. It is well to have all facilities readily available without the necessity of running here and there for equipment.

If the surgeon has administered the anesthetic, he should participate actively in the immediate postanesthetic maneuvers until conditions are within satisfactory control. The person to whom he entrusts his patient's welfare should, by instruction, be cognizant of the dangers that lurk in the background and realize the need for prompt and correct actions should untoward results appear or threaten.

The giving of a spinal anesthetic, walking away, and entrusting the patient to untrained or casual operating room personnel will result in generally unsatisfactory anesthesia and occasional harrowing untoward results or complications.

Summary and Conclusions

1. Spinal anesthesia in its simple form is often inadequate for present-day surgery.
2. Spinal anesthetists should be familiar with all techniques and drugs for spinal anesthesia to provide satisfactory and safe anesthesia in all circumstances.
3. The prime factor influencing the choice of anesthesia is the patient's physical status and not the surgeon's desire for ideal operating conditions.
4. Indications and contraindications are listed.
5. Adverse physiologic effects and complications of spinal anesthesia are discussed.
6. Technical considerations are discussed.
7. Meticulous minute-to-minute management of the patient during the first seven minutes after injection of a spinal anesthetic will influence success, failure, and untoward reactions.

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AMERICAN EARNING POWER

(Read, clip, and paste in your hat)

The cost of medical care is the biggest argument social planners have at their disposal in their crusade for government medicine. All such propaganda begins with the statement that millions of people lack proper medical care because they cannot pay the price. A great many learned arguments have been developed to prove that contention false, but none carry the appeal that is created in the public mind by the suggestion that we, as Americans, are not getting all we have coming to us. There are, however, two arguments that should settle this issue for any person who is willing to give the subject a moment's thought.

The first concerns voluntary prepaid insurance. There can be no doubt in the mind of anyone that a cooperative non-profit plan operated by physicians and subscribers will be less expensive than a comparable program directed by bureaus of the federal government. This fact is so simple, so conclusive, and so instantly apparent that no further discussion should be needed.

The second is more involved but can be used to dramatic effect if carefully introduced. Americans are dollar-conscious and have come to place absolute confidence in the gold standard as set by this nation. A few are only now beginning to learn the fallacy of this trust, discovering that a dollar is without intrinsic value. It is worth only a relative amount based on a formula that involves the amount of time a person must work to earn this dollar and what it will purchase. The possession of a dollar is of significance only in terms of what it costs and what it will buy.

A man recently returned from China illustrated this principle by telling of having purchased an airplane ticket for a 500-mile trip. This required a carload of bills in large denomination and occupied the time of 11 clerks for four hours merely in counting. In a recent speech in Kansas Mr. Louis Bromfield told of a German who paid off a 100-year-old mortgage on his farm through the sale of a wheelbarrow full of potatoes.

The important consideration is not whether an appendectomy costs \$150, but how long the patient has worked to earn \$150 and the relationship of that sum to the price of other commodities. The cost of medical care is not a problem to be answered in terms of dollars. If compared with other commodities, it will be found not to be excessive. If studied in relation to costs in other countries where socialized medicine exists, it will be found to be very low.

The Standard Steel Spring Company of Pennsylvania

has released some interesting statistics in its recent advertising literature. By way of example, they reported that in the United States a two-pants wool suit may be purchased for an average of 38½ hours of work. The Englishman would work 163 hours for that same suit, and the Russian 506 hours. In the length of time it would take the Russian to earn enough to purchase one suit, the American would have earned enough to buy 13. His purchasing power is four times that of the Englishman. Other items are comparable. Men's dress shoes may be purchased in the United States for 6¾ hours' work, in Great Britain for 25½ hours' work, and in Russia for 145 hours of labor. A cotton house dress requires 2¼ hours' work in this country, 10½ in Great Britain, and 28 in Russia. These figures are recent, carrying a date of February, 1949.

It is only natural, therefore, that Americans should own more commodities because their purchasing power is far greater. They are wealthier. In the United States one out of every four people owns a car; in socialist England there is one car for every 22; in communist Russia, one for 252. In the free United States one of every three people owns a radio; in England there is one for five, and in Russia one for 45. Or take the telephone. In America there is one telephone for every five people; in socialist England there is one for every 155; in communist Russia there is one for every 188.

It is of no more consequence whether a surgical procedure costs \$100 or \$1,000 than whether a suit of clothes costs \$10 or \$100. The important factor is how long a person must work before he can earn enough to pay for what he wants or needs. The purchasing power of the average American exceeds that of the citizen of any other nation. He is able to buy more necessities and also more luxuries. On the same basis his medical expenses will be less than elsewhere regardless of whether medicine is practiced under free enterprise or doled out by the government.—*Journal of the Kansas Medical Society*.

Indoctrination Course for Executive Personnel in County and State Societies

A suggestion from the Medical Society Executives Conference that an organized program for training newly designated executive personnel in county and state societies be developed was approved by the Board of Trustees of the AMA. The arrangements will be made through the Secretary and General Manager for an indoctrination course in the headquarters office.

Recent Advances in Contact Therapy Equipment and Usage

RICHARD H. CHAMBERLAIN, M.D.

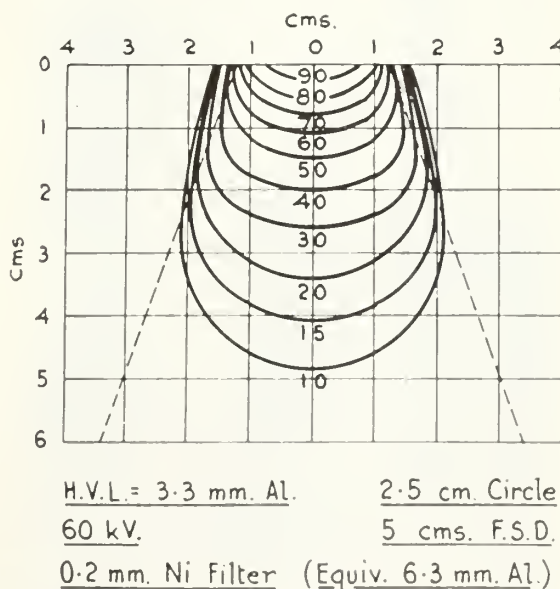
Philadelphia, Pa.

THE DEVELOPMENTS of electronic physics during recent years have resulted in remarkable advances in means for generating x-rays of very high energies. X-rays produced at potentials in the order of one hundred million volts are being studied and human cancer is being treated on an experimental basis with x-rays from the twenty million volt betatron. In the design and pilot stages are machines which may utilize voltages to the order of one billion volts. A large part of the medical interest in these very high energy radiation sources is associated with the possibilities for delivering high dosages of radiation to deep-seated tumors without exceeding the limitations of skin and intervening tissue tolerance.

At the same time, a corollary line of research has been developing in a less spectacular fashion for the production and use of x-rays of very low energy. Such "soft" or long wave length x-rays have the property of expending their energy superficially within a small volume of tissue and avoid penetration of the radiation effect to deeper-lying structures. Clinical x-ray therapy using this principle has been developed since 1929, under the term of "contact therapy," by Schaeffer, Chaoul,¹ Mayneord,² Pendergrass,³ and others. A notable improvement in apparatus for producing low energy x-rays has recently been made possible through improved technology for the element beryllium and use of it for windows in x-ray tubes.

Beryllium is a very light metallic element, the fourth element in the periodic table, and transmits much larger quantities of low energy x-rays than similar thicknesses of elements of higher atomic number. In malleable form it may be manufactured in sheets of 1.0 millimeter thickness which will be vacuum-tight when used as windows through which the x-ray beam emerges

from the tube.⁴ In the production of x-rays at the target of x-ray tubes by the cathode stream bombardment, there are always large quantities of low energy x-rays, but these softer components are usually absorbed in the glass of the tube and in the materials used for insulation and cooling in front of the tube window. With beryllium windows, these soft x-rays are transmitted to the outside and may be used for treatment either in unmodified form or after alteration by a wide choice of external filters to obtain a desired quality range. These tubes have extended the range of useful voltages from the order of 40 to 50 kilovolts down to about 5 kilovolts in addition to transmitting large quantities of soft radiation at any kilovoltage. The quantities of low energy x-rays are surprisingly high as measured in ionization effect in terms of r units. The output of a beryllium window tube may be as high as two million r per minute in comparison to a few thousand r per minute for a conventional tube operated under similar conditions. The increased dosage rate is due, of course, to increased trans-



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Fig. 1. Isodose distribution of radiation from the Chaoul (Siemens) tube at 5.0 cm. focal skin distance, 2.5 cm. circular portal.

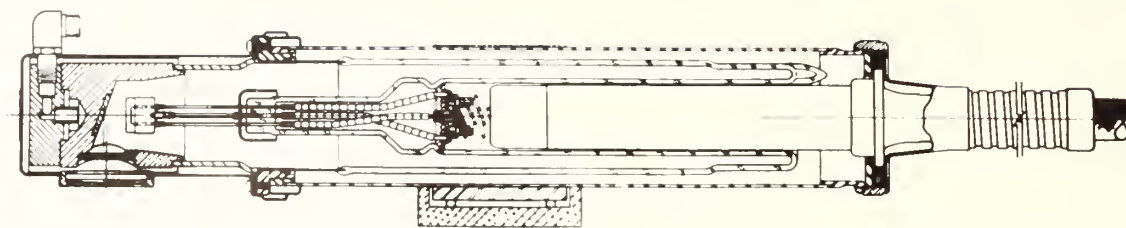


Fig. 2. Cross-sectional view of a beryllium window tube, Machlett AEG-50 tube. Courtesy of Machlett Laboratories, Inc.

mission by the window rather than to change in the production of radiation at the target.

The principles of contact therapy are useful only in the treatment of superficial disease or for lesions which are accessible through body orifices or by operative exposure. In such cases it is desirable to have a radiation source which will give a homogeneous dosage to the desired area, but also be limited to that area as much as possible. Other advantages may lie in easy application of portals with precise control of the area covered, ready availability at all times, and a high dosage rate so that the treatment period will not be too prolonged. In most of these factors, special apparatus designed for contact therapy is appreciably better than surface radium sources or conventional x-ray apparatus and the contact therapy range has been extended by beryllium window developments.

Contact Therapy Equipment

Most of the clinical work in contact x-ray therapy has been done with apparatus based on the design of Chaoul, as manufactured by the Siemens Company, or with the Phillips contact tube. The Chaoul tube delivers a comparatively highly filtered beam, generated at 50 to 60 kilovolts, but inherently filtered by transmission through the target itself. By this device it is possible to treat at very close distances to the target, but most of the low tissue penetration is due to the close distance, as is also the case with surface radium applicators. The Phillips tube, employing a thin glass window, transmits softer radiation and also allows close distance between the target and the skin. At voltages as low as 40 kilovolts it is less penetrating than the Chaoul radiation. The target skin distance is of importance because of the rapid decrease in dosage in compliance with the inverse square law. It introduces undesirable elements, however, in the shape of the dosage distribution in the tissues as shown in the isodose curve for a Chaoul tube in Fig. 1. The falling off of the dosage at the periphery may make it difficult to administer adequate dosage over the entire lesion without reaching too high a level in the central axis.

Beryllium window tubes which are suitable for contact therapy are currently available from the Machlett Laboratories and the General Electric X-Ray Corporation. The cross-sectional view of a beryllium window tube is shown in Fig. 2. These tubes permit several refinements as well as extensions in technique. By alterations in the kilovoltage applied to the tube and the filters that are placed in the beam, a wide choice of penetration qualities is available without recourse to short target skin distances. With the very high dosage output available, the target skin distance may be increased up to 10 to 25 centimeters. With very low kilovoltages, corrections may be necessary for the air absorption of the beam,⁵ but greater latitude in designing cones becomes pos-



Fig. 3. Direct view cones for use with beryllium window tubes. The lead foil masks allow any shape of portal.

ABSORPTION CURVES FOR PLEXIGLASS

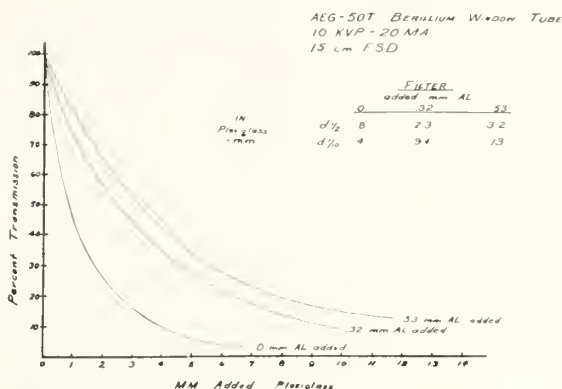


Fig. 4. Absorption curves for 10 kilovolt beryllium window tube radiation.

sible. The field may be viewed directly and lighted to ensure exact placement of the cone (Fig. 3).

With the very high dosage rates obtainable, there arises the necessity for particular care in the calibration and calculations of ionization output.⁶ Furthermore, the physical measurement of the roentgen becomes more difficult with lower energy x-rays. Much work has been done with the Chaoul and Phillips tubes and absorption curves and half-value layer measurements are satisfactory for most of the beryllium window output range, but the physical characteristics of the latter are not yet complete. A representative set of absorption curves for a beryllium window tube operating at 10 kilovolts is shown in Fig. 4. The absorption in plexiglass is sufficiently close to that in tissue to form a basis for clinical applications. A useful physical concept in choosing penetration quality of x-rays for clinical use is the expression of the depth in tissue at which the dosage is reduced to one-half of the surface value.⁷ This must be obtained by measurements within tissue equivalent phantoms, but an approximation of the value is seen in absorption curves such as those in Fig. 4. A comparison of the total range of thickness at which the dose is reduced to one-half, the $d_{1/2}$, for contact therapy apparatus is shown in Fig. 5.

Clinical Applications

Cancer of the Skin and Lip: Superficial malignant lesions may be treated with contact therapy techniques to obtain excellent results with the least cosmetic deformity. In the treatment of basal and squamous cell lesions there is

sufficient tumor sensitivity to fully utilize the therapeutic possibilities of radiation. Certain epitheliomas of skin adnexal origin are less sensitive and should be evaluated for the possibility of a better result from surgery. Malignant melanomas are quite radioresistant and require cauterizing dosages of radiation which are outside the scope of this paper and, in general, should not be treated with x-ray therapy.

An example of contact therapy management can be appreciated in the case of a small epithelioma of the skin, preferably located in an exposed area where the cosmetic result is a factor. The area and depth of the lesion are estimated plus a margin of 0.5 to 1.0 cm. in each plane. By referring to physical tables of depth penetration, factors of kilovoltage, distance, and filter may be chosen which will give a $d_{1/2}$ at the deepest level of the lesion plus margin. The range of dosage throughout the tumor can then be determined from isodose curves, and the maximum and minimal r dosage, as well as the uniformity of coverage, can be ascertained. Similar physical control is adaptable to surface radium techniques, but with less flexibility and uniformity of coverage. A basal cell epithelioma may be satisfactorily treated by this method with total dosages in the range of 8000-10,000 r maximum to 6000-7000 r minimum within the tumor. The treatment of larger tumors is planned with multiple portals by similar calculations. When crossfiring portals are possible, as in tumors of the lip, even greater uniformity of dosage is possible, with full protection to adjacent normal tissues.

Lesions of the Cornea: Excellent clinical results have been obtained in the treatment of

$d_{1/2}$ cm	BERYLLIUM WINDOW - AEG 50 10-100 KV	PHILLIPS 45 KV	CHAUL SIEMENS 50-60 KV	SUPERFICIAL- INTERMEDIATE 80-140 KV
0.5				
1.0				
1.5				
2.0				
2.5				
3.0				
3.5				
4.0				
4.5				
5.0				

Fig. 5. Ranges of $d_{1/2}$ values for contact therapy equipment. Adapted from Smithers.

corneal vascularizations and opacities by the beta rays of radon and, more recently, by the beta rays of radium D and E. In this use of radiation it is important to limit the radiation to the cornea as much as possible and to administer the least possible radiation to the lens in order to avoid the late radiation cataract changes. Results comparable to those obtained with radon can be effected with the Phillips tube, but the dosage to the lens with this apparatus has been higher than is desirable. With the beryllium window tube we have recently employed x-radiation generated at 10 kilovolts, no added filter, and 10 cm. target-cornea distance. These factors give a $d\frac{1}{2}$ of 0.8 millimeter and about 10 per cent at 5 millimeters, the average depth of the lens. The target skin distance of 10 cm. also allows satisfactory treatment of the margins of the cornea, as the reduction in intensity is almost entirely by tissue absorption rather than by inverse square law relationships. The beryllium window tube also permits ease in control of size and placement of the portal, under direct visual control, and there is constant availability of the equipment, which is not true in the use of radon sources.

Hemangiomas: The principles of precise control of depth penetration are of particular importance in the treatment of benign lesions in children. The excellent results from radiation therapy of cavernous hemangiomas have been fully reported,⁸ but x-ray treatment should be used only when protection to underlying growing tissues is ensured. Contact therapy and its extension with beryllium window tubes is particularly adaptable to this use. The very low penetration range of beryllium window tubes makes it possible to treat the very superficial vessels in the nevus flammeus form with somewhat higher dosage than had been permissible with other x-ray sources. The best results have been obtained when these lesions have been treated initially in the first few weeks of life.

Research Uses: Due to the absorption of the low energy x-rays by thin sections of tissue, the beryllium window tubes also have applications in radiography of microscopic sections. Brilliant demonstrations of the arteriolar circulation of the kidney and stomach by Barclay and co-workers were accomplished by such visualization of vessels injected with radiopaque substances. The

existence and action of shunt mechanisms in the arteriolar circulation were demonstrated in both organs⁹ and are of considerable physiologic significance. Further adaptations of special beryllium window tubes with thinner windows allow true microscopic demonstration of the distribution of certain chemical elements in tissues. An example of this adaptation is seen in the use of windows of 0.1 mm. thickness, so thin as to require constant evacuation of the x-ray tube to maintain the vacuum, whereby Marinelli and co-workers have been able to show the distribution of total iodine in microscopic thyroid sections.¹⁰ Similar radiographic adaptations have been useful in industrial examinations of small castings, welds, and thin materials.

Summary

When it is desirable to irradiate superficial and accessible lesions, low energy x-rays may be used to furnish uniform and precise dosages without excessive irradiation of normal underlying tissues.

The scope of usefulness and flexibility of choice of such "contact" therapy has been greatly widened by the application of x-ray tubes with beryllium windows. These windows pass much greater amounts of low energy x-rays than have been obtainable before, but require precise physical calibration.

Very low energy x-rays are of particular use in accessible cancer, certain lesions of the cornea, hemangiomas, and research adaptations to microscopic radiography.

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CHORIONEPITHELIOMA

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TRUE chorionepithelioma is a rare tumor. Errors in diagnosis are frequently made, and often suspected chorionepithelioma proves to be histologically benign proliferative hydatidiform mole or syncytial endometritis. Clinical follow-up is of great importance and the fact that the patient died speaks for the correctness of the diagnosis of chorionepithelioma.

A comprehensive study of this type of malignant tumor is being made by the Albert F. Mathieu Chorionepithelioma Registry.¹ Tissue obtained at autopsy was sent to the chairman of the Registry, Dr. Emil Novak,² who concurred in the diagnosis. The other four members of the Registry were unanimous in their diagnosis of chorionepithelioma.

The case is reported for three reasons: (1) It was a genuine chorionepithelioma, and (2) when the patient was first seen by us she had only one complaint, dyspnea. The history of bleeding following a spontaneous delivery, the irregular enlargement of the fundus uteri, together with cough and hemoptysis, lead to the suspicion of pulmonary metastases. (3) This is the only case of chorionepithelioma (in a female) in the history of the Elizabeth Steel Magee Hospital during the 24-year period (1921-1945). During this period there were 59,300 deliveries.

Case Report

Mrs. B. Z., white, age 23, gravida II, para II, was admitted to the Elizabeth Steel Magee Hospital on Oct. 24, 1945. The chief complaint was cough with blood-tinged sputum and pain in the chest. These respiratory symptoms began two weeks before admission. There were two full-term pregnancies with spontaneous deliveries. The last delivery occurred five months before, and since that time the patient had three episodes of irregular bleeding. The uterus was packed during the first hemorrhage and the patient had office cauterization of the cervix for the last episode of bleeding. The family history was negative for cancer.

The blood count showed 2,010,000 red blood cells, hemoglobin 45 per cent, white blood cells 16,150, with polymorphonuclear cells 83 per cent, lymphocytes 15 per cent, and eosinophils 1 per cent. There was marked anisocytosis and poikilocytosis. The sedimentation rate was 23 minutes. Two biologic pregnancy tests were positive and these were run during an interval of six days. The Aschheim-Zondek test was positive. The Friedman test was also strongly positive. One cc. of urine was diluted with 9 cc. of normal saline for the rabbit test. An x-ray of the chest revealed multiple widespread soft tissue masses involving both lung fields. These masses varied in size from 1 cm. to 4 cm.

Physical examination revealed an acutely ill, poorly nourished young woman showing evidence of secondary anemia, and the lips were cyanotic. She was dyspneic and in distress. The cough produced blood-tinged sputum. The blood pressure was 150/60. Pelvic examination revealed normal external genitalia. The perineum was well supported. The cervix was lacerated and the cervical canal was free of blood. The external os was closed. The uterus was anterior and freely movable. There was a soft doughy enlargement felt in the fundus uteri on the right side. The clinical impression was that the patient had a chorionepithelioma with typical "cannon ball" metastases in the lungs. The clinical course was progressively worse and, because of extensive involvement of the lungs, oxygen was necessary for the last fifteen days of life. During this time there was no uterine bleeding.

Autopsy was limited to the pelvic organs. The uterus was enlarged. On the posterior aspect of the fundus uteri on the right side there was a large friable hemorrhagic mass which extended to and was adherent to the reflected peritoneum on the anterior aspect of the



Fig. 1 Uterus and adnexa. The chorionepithelioma has invaded the myometrium. The ovaries are enlarged due to multiple lutein cysts.

Presented before the Pittsburgh Obstetrical and Gynecological Society, Nov. 7, 1949.

From the Department of Gynecology, University of Pittsburgh.

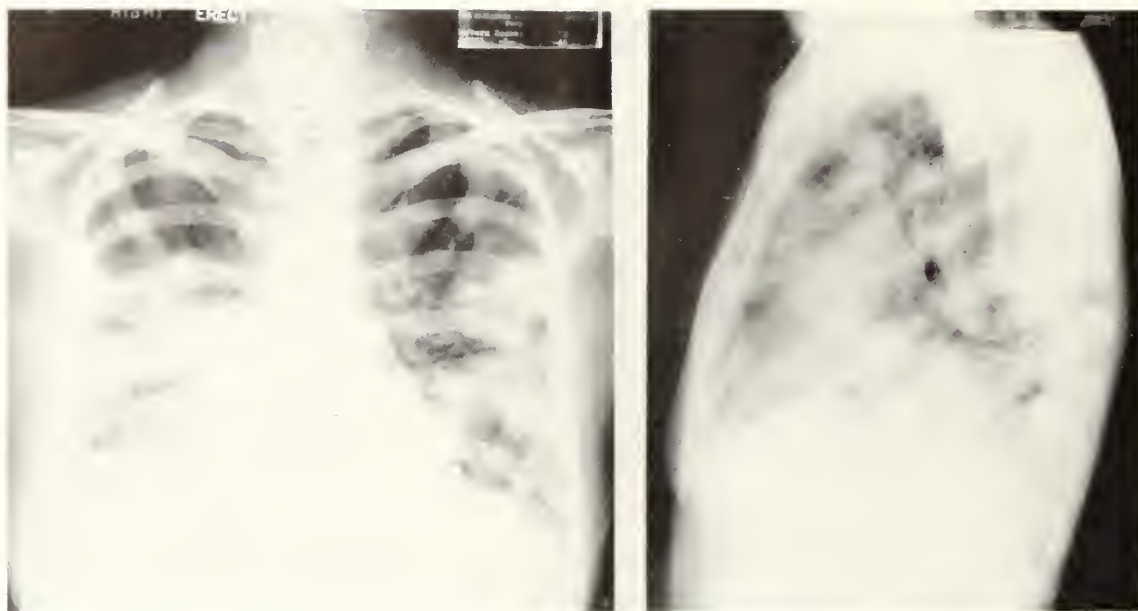


Fig. 2. Chest plates. Anterior view and lateral view of chest showing multiple spherical soft tissue masses throughout both sides of the chest. Typical "cannon ball" metastases are present.

rectum. After removal of the uterus, a portion of the tumor remained on the peritoneal surface of the rectum. The uterus measured 11 cm. between the cornua, and the length from fundus to cervix was 10 cm. On the posterior surface of the fundus at the right cornual area

there was a friable hemorrhagic dark reddish mass 4 cm. in diameter. On section this mass was seen to extend from the right cornual region through the myometrium. As the tumor eroded the myometrium it had a reddish-yellow appearance. The ovaries were enlarged and measured 8 cm. and 6 cm. in diameter respectively.

Microscopic sections of the tumor showed large irregular masses and islands of both syncytial and Langhans' cells. These cells were highly pleomorphic and mitotic figures were abundant. Adjacent to the large masses of trophoblast there was much hemorrhage, fibrin, areas of necrosis, and many inflammatory cells. There was a disorderly growth of trophoblastic tissue throughout. Further sections of the uterus showed that the tumor had eroded through the myometrium. No endometrium was seen and it was replaced by large sheets of tumor cells. Sections through the ovaries showed multiple lutein cysts.

Summary

A case of chorionepithelioma uteri with extension to the peritoneum and lungs is reported.

This is the first case of true chorionepithelioma in the Elizabeth Steel Magee Hospital in a total of 59,300 deliveries over a 24-year period.

EDITOR'S NOTE: The general practitioner in this case made the correct diagnosis before he sent the patient to the hospital.

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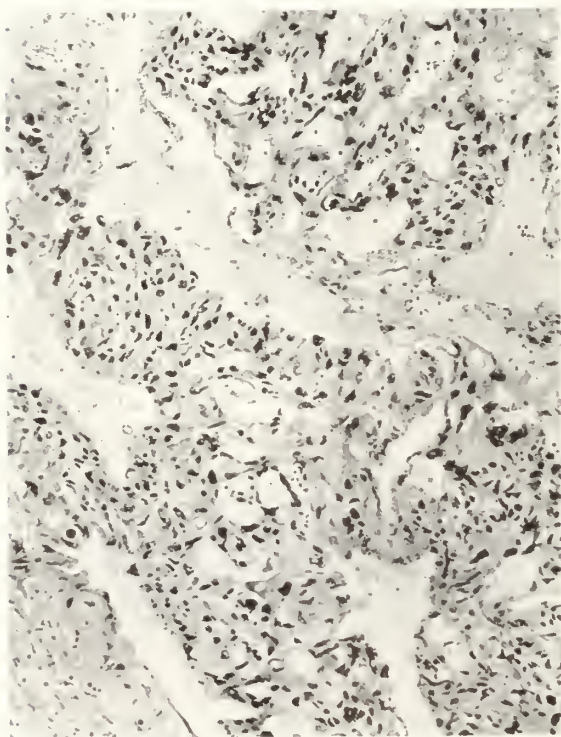


Fig. 3. Section of chorionepithelioma showing disorderly growth of trophoblast of both syncytial and Langhans type.

Medical Management of Gross Gastro-intestinal Hemorrhage

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WE RARELY encounter a medical emergency requiring greater expertness and experience on the part of the physician than the management of a case of gross gastro-intestinal hemorrhage. In the majority of cases the bleeding arises from a peptic ulcer, but we must be alerted to the possibility of hemorrhage from other lesions of the stomach and duodenum together with esophageal and small bowel lesions. The management of the case must be based on a diagnosis of the *probable* cause of the bleeding. In some instances the cause of the bleeding may not be apparent and measures must be directed toward combating the hemorrhage without regard to its cause. No single plan of treatment is applicable to all cases.

A careful history is of paramount importance, although in a severe case too much time may not be available to obtain an initial complete history. Members of the family may supply important data. Some of the historical data may be elicited only after certain preliminary measures of restitution have been started. The physical examination often must be of a brief type, but the presence of pallor, sweating, restlessness, rapid pulse rate, and low blood pressure should be noted. The most gentle examination of the abdomen should be employed. Most often the abdominal examination will not reveal any positive signs of disease. In other cases there may be evidence suggesting cirrhosis of the liver or some other type of disease which may be causing the hemorrhage. In a patient in whom there is some doubt about the presence of melena, a rectal examination should be done in order to ascertain the presence or absence of tarry material or fresh blood. The presence of tarry material on the examining finger usually denotes upper gastro-intestinal hemorrhage. In severe cases with massive bleeding from the upper part of the gastro-intestinal tract, fresh bright red blood may ap-

pear in the rectum. Fresh blood in the rectum in the absence of severe hemorrhage suggests a lesion in the lower part of the gastro-intestinal tract. The pulse and blood pressure should be recorded at frequent intervals depending on the severity of the hemorrhage. A knowledge of the patient's usual blood pressure is helpful. A systolic blood pressure of 120 mm. Hg. would be regarded as normal in the average individual, but might represent a pre-shock value in a patient who had a blood pressure of 180 to 200 mm. Hg. prior to his hemorrhage.

The usual laboratory procedures employed in the study of the hemorrhage case have been discussed in another paper presented at this meeting, nevertheless some repetition is in order because a great deal of the management is predicated on the results of certain laboratory procedures. A complete blood count should be available at the beginning of treatment including red blood count, hemoglobin, white blood count, hematocrit, typing and prothrombin time. These tests should be repeated daily for the first few days in severe cases and correlated with the probable influence of dilution, hemoconcentration, and the effect of transfusions. Blood transfusions are the most important factors in the early management of acute severe hemorrhage, and we must have available certain standards of values of the blood in order to intelligently utilize transfusions. One may estimate blood loss by determining the circulating plasma volume using T-1824 (Evans blue) and calculating the total blood volume from the hematocrit reading and weight of the patient. Despite some theoretical inaccuracies of the procedure, it has proved useful in the hands of its proponents. We have not used the method and therefore cannot evaluate it from our own experience. Likewise we have not used the tilt test of Green and Metheny to determine the amount of blood necessary to transfuse into the patient.

We determine the blood urea nitrogen shortly

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after admission to give a base line on alimentary extrarenal azotemia. With brisk hemorrhage into the gastro-intestinal tract within a 24-hour period prior to admission, we expect the initial blood urea nitrogen to be normal unless there is coexistent renal disease, chemical imbalance, or shock. In extrarenal azotemia we expect the blood urea nitrogen to reach a height about 48 hours after the hemorrhage, after which the blood urea nitrogen should gradually approach a normal value within a week. A subsequent rise in the blood urea nitrogen may be the sole indication of recurring gastro-intestinal hemorrhage. In severe recurrent bleeding, usually the signs of hemorrhage will be evident apart from a secondary rise in the blood urea nitrogen.

A routine stool and urine examination should be obtained from the first specimens passed by the patient. In severe hemorrhage the blood carbon dioxide combining power and serum chlorides may give information concerning the presence or absence of chemical imbalance.

In a patient in whom bleeding esophageal varices are suspected secondary to cirrhosis of the liver, a prompt determination of the bromsulfalein excretion may give valuable data. In patients with normal livers, even in the presence of severe hemorrhage, the bromsulfalein excretion usually is normal. We use 5 mg. of dye per kilogram of body weight and extract the specimen at the end of 45 minutes. A value in excess of 8 to 10 per cent retention of the dye is abnormal. In cirrhosis of such severity as to cause bleeding esophageal varices, one may anticipate a bromsulfalein value of 20 to 40 per cent. If there is any suspicion of hepatic disease on the basis of either history or a positive bromsulfalein test, a bank of liver function tests is recorded including the cephalin cholesterol, thymol turbidity, thymol flocculation, colloidal gold and quantitative serum bilirubin (direct and total), and urinary urobilinogen. Any suspicion of intrinsic disease of the hematopoietic system will call for special studies of the blood.

Our initial efforts in treating a case of severe hemorrhage from the upper part of the gastro-intestinal tract revolve around three objectives: (1) to combat the effects of shock and blood loss, (2) to maintain an approximate urinary volume of 1000 cc. daily, and (3) to correct any chemical imbalance in the blood such as acidosis or alkalosis.

For convenience we may classify our gastro-

intestinal hemorrhage cases in order of ascending severity in the following groups: (I) mild melena in known cases of peptic ulcer in the absence of any vomiting, (II) severe melena without vomiting but with evidence of actual or impending shock, (III) severe hemorrhage with hematemesis, (IV) severe uncontrolled hematemesis and melena while under treatment, (V) severe hemorrhage with suspected acute perforation.

Cases in Group I occur more often than hospital statistics indicate. One may have mild melena from as little as 50 cc. of blood poured into the gastro-intestinal tract. Patients frequently pass tarry stools without any apparent ill effects. A well-instructed peptic ulcer patient should be alerted to the significance of melena. Often even after passing several tarry stools there may be no reduction in blood pressure, elevation of pulse, or evidence of shock. These patients require immediate bed rest, preferably in a hospital. One never knows how severe an initial apparently innocuous melena may become. Since a previous diagnosis of peptic ulcer has been established in Group I, we put the patient to bed, give mild sedation with barbiturates, and begin prompt feedings of milk, milk and cream, or milk formula using 4 to 6 ounces hourly during the waking period. We may use whole milk, a mixture of two-thirds milk and one-third cream, or a formula such as the following:

Protein hydrolysate	60-80 grams
Dextrin	60-80 grams
Whole milk	1000 cc.
Vanilla flavoring	15 cc.

Skim milk powder or calcium caseinate may be used instead of protein hydrolysate. If no complication occurs, the patient in Group I is carried along on a graduated peptic ulcer program similar to that used in non-hemorrhagic cases. Adequate amounts of parenteral vitamins B, C, and K are administered even in the absence of any clinical evidence of vitamin deficiency. When it is evident that the melena is mild, I give a dram of colloidal aluminum hydroxide midway between each feeding.

In Group II (severe melena without vomiting but with evidence of actual or impending shock) prompt measures must be instituted to compensate for the loss of blood. Hospitalization is of paramount importance in these cases, but long ambulance trips to enter a particular hospital should be discouraged. Basic studies of the blood

must be promptly made including typing, red blood count, hemoglobin, white blood count, hematocrit, blood urea nitrogen, prothrombin time, blood carbon dioxide combining power, and serum chlorides. Pending the cross-matching of the blood, it may be necessary to begin intravenous plasma. Compatible blood in amounts varying from 500 to 1500 cc. is given as soon as practicable after admission to the hospital. Frequent determinations of the pulse and blood pressure are recorded. Subsequent indications for further transfusion will depend on the clinical response of the patient, an admittedly intangible factor in which the clinical experience of the physician is so important. It is here that an attempt to measure the depleted blood volume with Evans blue dye may be of the greatest value in the hands of those familiar with the technique.

I favor the prompt feeding program for this group as outlined for Group I unless vomiting supervenes, in which case parenteral nourishment is carried out as outlined for Group III. I hesitate to order colloidal aluminum hydroxide on admission for patients in Group II because of the well-known possibility of intestinal obstruction following the mixture of blood and colloidal aluminum hydroxide. Usually I use no antacid during the first two or three days, relying on the oral feedings to keep the gastric acid busy. I dislike the use of soluble alkalis such as sodium bicarbonate in these instances, but if alkali is required, I prefer a combination of calcium carbonate and magnesium oxide. Two or three days after the cessation of the hemorrhage, colloidal aluminum hydroxide may be used with safety.

In Group III, in which we have the factor of hematemesis in addition to the general considerations listed in Group II, we withhold the prompt feeding program. There is no point in attempting to feed a bleeding patient who is vomiting. As soon as the vomiting subsides, a feeding program such as outlined for Group I is instituted. Pending that time, nourishment and an adequate fluid balance are maintained by the use of intravenous fluids, using glucose and water (or saline), plasma, and protein hydrolysate. Occasionally hypodermoclysis is utilized, but generally we prefer the intravenous route. It is impracticable under those circumstances to maintain adequate nutrition by the parenteral route, and we use oral feedings as soon as the vomiting has ceased.

Usually the vomiting of patients in Group III

is the result of the hemorrhage itself, but occasionally it is the result of pyloric obstruction which has already supervened on an active ulcer. In the latter instance more than the usual care must be taken in determining alkalosis secondary to loss of gastric chlorides. A good plan in such cases is to give parenterally that amount of saline which is equivalent to the material vomited plus one liter of saline daily with sufficient other parenteral fluids to insure a urinary output of one liter daily. If the above plan is followed carefully, alkalosis usually will not occur during the treatment period. If, in such a case, prolonged vomiting has occurred prior to the current observation, one must rely on the determinations of blood chemistry for guidance, i.e., blood carbon dioxide combining power, serum chlorides, and blood urea nitrogen. Cases of cirrhosis of the liver with bleeding from esophageal varices present special problems in therapy that seem beyond the confines of this paper, which is more concerned with the peptic ulcer patients.

In Group IV, in which uncontrolled bloody vomiting and melena persist while under treatment, consideration must be given to surgical intervention. We may subdivide this group into two parts: (a) those patients in whom the bleeding apparently does not cease under medical management, and (b) those in whom the bleeding ceases for a few days and then recurs. In the former group, uncertainty of diagnosis may be present. In a previously unstudied case one must give consideration to all of the possible causes of gastro-intestinal hemorrhage. A normal bromsulphalein excretion test tends to rule out bleeding from esophageal varices in cirrhosis of the liver. Occasionally, following a prolonged bout of alcoholic ingestion, uncontrolled hemorrhage may occur diffusely from the gastric mucosa. Occasionally a carcinoma of the stomach presents itself initially with uncontrolled hemorrhage. More rarely, and usually without hematemesis, severe uncontrolled melena may be due to a tumor of the small intestine such as leiomyoma or leiomyosarcoma. Peptic ulcer hemorrhage, particularly in patients over 45 years of age, may be associated with an open artery in the center of an ulcer crater. If a comprehensive medical effort to control hemorrhage fails in 24 hours, surgical exploration of the abdomen is mandatory. What the surgeon does at the time of operation will depend on his findings.

In those cases in which the hemorrhage ap-

parently has ceased but recurs after a day or two of medical treatment, serious consideration should be given to surgical exploration. Certainly no more than a 24-hour delay should occur between the repeated hemorrhage and the operation, and during that period every effort should be made with transfusions and all adjuncts to bring the blood volume to as near normal as possible prior to surgery.

In Group V, in which severe hemorrhage is present in association with a suspected acute peptic ulcer perforation, immediate surgery is indicated.

Apart from a consideration of the immediate

care of the patient with gross gastro-intestinal hemorrhage, the internist should have a policy with reference to the future of the patient with peptic ulcer who has had a severe gastro-intestinal hemorrhage. I believe that all patients over 45 years of age in whom a severe gastro-intestinal hemorrhage has occurred due to peptic ulcer should be candidates for an elective subtotal gastric resection in an interval period unless some obvious contraindication exists. In a younger patient with similar findings, particularly between the ages of 20 and 30 years, a subtotal gastric resection is mandatory after a second gastro-intestinal hemorrhage.

AN OPEN LETTER TO OSCAR R. EWING

The medical profession is deeply interested in your current visit in Europe "to study the operation of compulsory health insurance already in effect abroad."

As a matter of fact, it should be of interest to *all* taxpayers when government representatives start traveling. Why not? The cost of such trips is borne by John Q. Public.

But the doctors of America have a particular interest in this journey of yours, Mr. Ewing, because you have stated that if you find socialized medicine is a flop in Europe you intend to say so.

"Where we find something wrong," you told newspaper reporters on the eve of your departure on December 1, "we will find out why it is wrong so that if we go into this field we will not be making the same mistakes. I am a firm believer in compulsory health insurance, but if I find anything that would shake my faith I would say so."

If you really mean that, Mr. Ewing, we can hardly wait until you get back. It will be a treat to hear from you—as we have heard from other sane, well-balanced men who have a regard for the future of this democracy—that the effect of compulsory health insurance on the financial structure alone of England has been disastrous.

You are our Federal Security Administrator, and should have the clear knowledge of economics which the job demands. If so, you must have read the reports of conditions in England under socialized medicine—and they ought to scare you!

Maybe you don't believe it. Maybe that's why you're over there to see for yourself, first-hand.

But don't pull any fast ones on us, Mr. Ewing!

Don't go to Health Minister Aneurin Bevan for your information. It's all sweetness and light, milk and honey to him. It's the great common denominator, the great

leveler. It's the scheme by which you get something for nothing—and let "the toffs" worry about paying for it.

Go to the average English doctor for your data, Mr. Ewing, to the ordinary physician who's overworked, underpaid, and rapidly becoming a mere dispenser of pills, wigs, spectacles, false teeth and certificates; then visit the treasury and find out how much the socialized medical program is costing, and how deeply it is to blame for the near-ruin of England's finances.

You are "sold" on socialized medicine, so the answers may fail to convince *you*. But if you pass unbiased information along to the American public upon your return, we will be content, Mr. Ewing.—*Philadelphia Medicine*, Dec. 3, 1949.

REFEREE CARRIES THE BALL

What a furore such a violent reversion of the rules of the game would occasion at a football contest. How the paying spectators would overrun the field to eliminate the referee who claimed a touchdown.

Why don't the American taxpayers overrun the political field on election day and eliminate the administration that as a "playing referee" carries the ball with tax money and runs the potato and the egg business, utilities, etc?

The answer is that (1) too many taxpayers don't understand the Constitutional limitations against governmental interference with "free enterprise"; (2) too many of those who do understand don't speak out to their neighbors, don't register to vote, and don't support candidates for office who do support the Constitution of the United States.

CEREBRAL TRAUMA

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ASSUMING that the initial shock has been adequately combatted, the first step in handling a case of cerebral trauma is to carry out a rapid, but complete, survey of the case. In taking the history, particular emphasis must be laid on what information can be obtained concerning the forces involved in and the mechanism of the injury and the period of unconsciousness. If no detailed information is available, some estimate of the period of unconsciousness can be obtained from the patient by checking his period of amnesia. Following this, a local examination of the head, a general physical examination, a careful neurologic survey, and x-ray examination are indicated. Spinal puncture for pressure and removal of one cubic centimeter of fluid is usually safe. In the occasional case, a special examination, such as electro-encephalography or ventriculography, may be undertaken.

From the standpoint of therapy, head injuries may be considered in three groups. The first of these might be described as the mechanical type of injury, in which there is trauma to the overlying structures of the head as well as to the brain. These include scalp lacerations, compound fractures of the skull, penetrating wounds of the skull, and depressed fractures of the skull. Here, the diagnosis is usually fairly obvious and the need for early operation with débridement of the wound and closure is apparent. The extent of the associated underlying brain injury may regulate somewhat the timing of this operative therapy, but, in general, it is carried out relatively soon after admission.

The second type of injury might be described as a bruising trauma, and these are the patients who are usually handled by non-operative methods. The initial step here is to institute a program of observation by check on the vital signs of temperature, pulse, respirations, and blood pressure, and perhaps occasional repetition of the

physical and neurologic examinations. Second in importance is the attack on the rising intracranial pressure as a prophylactic measure or to combat the pressure if it is already established. One small measure which is very important here is the placing of the patient in the Fowler position with the head elevated. Third in importance is the maintenance of an adequate airway. Dehydration per se is usually not practiced extensively, but there is no doubt that in certain patients a brief period of increasing cerebral edema may be very critical for the patient and can be combatted successfully by the use of hypertonic solutions. The sugar solutions and salt solutions have proved to be relatively ineffective, but hypertonic plasma or normal serum albumin definitely reduce the cerebral swelling.

The maintenance of the cerebral oxygen supply is a very important item in the care of these patients. They should be positioned in such a way that the tongue does not fall back and obstruct the airway. Mucus should be aspirated. The patient should be turned from side to side. Transfusions should be given if the blood count is low, and oxygen should be supplied, either by a tent or nasal catheter, in the critical case. The problem of sedation arises frequently. There is still strong opposition to the use of morphine because of its effect on the pupils and the respirations, but barbiturates, chloral hydrates, bromides, or paraldehyde are all valuable. The fluid balance of these patients can best be maintained by the use of a nasal Levine tube for feeding and an indwelling catheter. Control of a rapidly rising temperature may occasionally present a serious problem which can be met by using tepid sponges, ice bags, cooling fans directed over the patient, ice water enemas, or even ice packs.

The third type of head injury is that in which intracranial hemorrhage of some sort develops and includes middle meningeal hemorrhage, subdural hemorrhage (acute or chronic), and intracerebral hematoma. For the most part, these lesions develop after the first few hours, and their

detection is based largely on changes in the patient's condition. These changes might be considered in three classifications: first, the clinical deterioration of the patient—increasing stupor, rising temperature and blood pressure, slowing pulse and respirations, and progressive focal neurologic changes; second, the x-ray changes—if the patient is becoming worse clinically, ventriculography or occasionally pneumo-encephalography or even arteriography should be employed without hesitation in an effort to locate any intracranial massive hemorrhage; and, finally, if any doubt exists or if there are reasons why air injection should not be undertaken, exploratory burr holes or even occasionally exploratory subtemporal decompression or craniotomy are justified in a desperate case. (Slides represented illustrative cases; first, one of me-

chanical injury—a depressed fracture of the skull with laceration of the dura and brain; second, a penetrating gunshot wound of the head; third, a case of contusion of the brain; fourth, a patient with a middle meningeal hemorrhage; fifth, a case of subdural hemorrhage).

In conclusion, then, we should like to emphasize the importance, in dealing with cases of head injury, of the initial clinical and x-ray survey of the case; of early operation where the mechanical type of injury to the skull, meninges, or brain is present; of constant observation of the non-operative type of patient to permit the earliest possible detection of evidence of intracranial hemorrhage of any type; and, finally, of the use of pneumograms or exploratory burr holes whenever signs of general or focal clinical deterioration appear.

TAX AND TAX, AND GIVE ORDERS!

Of the forty billion dollars collected by the Federal government in the fiscal year 1948, five and one-half billion were returned to the states. Ohio taxpayers paid in \$2,665,707,099 and got back \$236,982,646, or 9 per cent.

All of which indicates several things:

It's costing too much to run the Federal government.

The states are being gypped.

There should be a reapportionment of taxes to leave the states and local governments a fairer share of taxes.

Until reapportionment is achieved, the Federal government is going to continue to tell the states and local units how to run their affairs as they will continue to be dependent on the U. S. for money.—*The Ohio State Medical Journal*.

A SIGNIFICANT CONFESSION

In the *Journal of the Tennessee State Medical Association** it is said that the President of the United States confessed that he "just can't find satisfactory definitions of the 'welfare state,' 'collectivism' and 'statism.'" "In fact," he said, "they are scare words." These words have been well defined and it may be that the definitions so clearly reveal the President's own political purposes he is afraid to look them in the face. Since the President already is far on the road to statism and doesn't know how to read the signposts, the people

must claim their government and through public sentiment and congressional action they must take a hand in its management.

In the same *Tennessee Journal*, Senator Dulles is quoted as saying, "Statism represents man's conceit that he can build better than God. God created men and women with great moral possibilities—industry, thrift, creativeness, self-control, compassion, love of God and fellow man. These qualities are the foundation of every good society; and government should be a way to give these qualities cooperative expression. But sometimes those in power lose faith in their fellow men. So they take more and more of the fruits of human labor so that they may, as they think, do more and more for human welfare. That process destroys the individual's incentive to produce and destroys his sense of social responsibility. It makes human beings into mere cogs in a man-made machine."

Dulles' definition and his recent defeat may well serve as an ominous warning, an evil omen. Only an intensive educational program wisely and persistently pursued can save us from destruction. Considering the fact that in other countries, already crushed by general socialization, medicine has served as the entering wedge and is being so employed here, we must engage all people interested in personal liberty and free enterprise in a determined fight for freedom. If we lose the fight for medicine, freedom is gone; if we lose freedom, medicine is gone. All good citizens should pool their influence in the protection of their interests.

Only through education and the grace of God can we hope to preserve the good life vouchsafed by our founding fathers.—*Journal of the Oklahoma State Medical Association*.

* "Who's Scared of Words?" *The Journal of the Tennessee State Medical Association*, 42: 364, October, 1949.

Physiologic Problems of the Premature and Newborn Infant

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THE GENERALLY accepted definition of prematurity is an arbitrary one—an infant under five and one-half pounds of weight at birth. Perhaps an arbitrary definition is best, and in any case it is better based on weight than on the uncertain timing of gestation. But the infants born of multiple births, twins, triplets, etc., are more frequently under this weight than above it, although they may not be prematurely born. Everyone knows this and accepts the fact that any arbitrary standard must have exceptions. The only point in mentioning it here is to emphasize that prematurity is a matter of degree and that the accepted definition is simply an indication of its upper limit.

That one cannot generalize on this subject is shown clearly by the mortality rates as they vary with the infant's size. There are several published series which include several thousand premature infants and the observations of them all are similar. These are to the effect that the smaller the infant, the higher the mortality rate. On this account an over-all figure for the mortality of premature infants is nearly valueless. This is especially evident when it is considered that the largest sized group in the subdivision of prematurity is the group between five and five and one-half pounds, where the mortality rate is very low indeed. The infants in this weight range are on the border between prematurity and babyhood and physiologically lie nearer the latter than the former. These infants require little if any more care than those just in excess of five and one-half pounds and should cause no more concern.

The premature infants which concern us as special problems are, for the most part, those under four and one-half pounds and the more

under this weight, the more concern they cause us. These infants are unable to maintain body temperature. They bleed unexplainedly, are subject to cyanotic attacks and become edematous readily, and they are extremely susceptible to infection.

If they survive their first day of life, their chances of continuing are much improved because they have weathered the first great risk—sufficient cerebral damage to overpower them from pressure in the birth process.

The heads of these infants are not as calcified as the head of the full-term infant. The brain is not as resistant to pressure. Its texture is much like junket, while that of the full-term infant more closely resembles that of an adult. Trauma is easily possible and damage once resulting is often extensive. The relatively high incidence of mental defects and cerebral palsy (sometimes found to total as much as 10 per cent) among premature infants is in part ascribable to their cerebral fragility.

The second great hurdle for the prematurely born infant is his first breath. His ribs, too, are soft and his rib cage pliable, but he must develop as much, if not considerably more, negative pressure for his first breath than full-term infants require. His pulmonary alveoli are less well developed and more heavily surrounded by parenchymatous tissue than are those of the full-term infant. On these accounts he finds expansion of them difficult. The pressures required to expand the lung of an infant of two and one-half pounds were measured by Clement Smith and found to be considerably in excess of any which are possible in the usual resuscitator. Because the required pressure is great, resuscitation with an anesthesia machine is probably the method of choice since positive pressure can be regulated by pressing on the bag while oxygen is being ad-

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ministered. One of the chief reasons for placing this method as the first choice is the ease with which it can be accomplished. A second method, which requires more skill but is at least as effective, is the introduction of a loose-fitting catheter into the trachea and admitting free flowing oxygen. This necessitates visualizing the larynx and must not be attempted without a clear view, as oxygen in the stomach may do more harm than good from the distention that it induces. If neither method is available, it must always be remembered that mouth-to-mouth breathing can supply the necessary pressure and that the 16 per cent of oxygen in the expired air of the resuscitating physician is not much less than the 21 per cent of the inhaled air and is much more than the non-breathing infant is obtaining. Any danger in this method appears to lie in overenthusiastic pressures, but perhaps this has been somewhat exaggerated.

One of the greatest difficulties in the resuscitation of any newborn infant lies in the fact that he can so completely block his airway with his tongue. On this account the tongue should be pressed forward and, when a mask is applied, the infant should, desirably, be open-mouthed and prone. In addition, when it is possible to do so, the infant should be in an atmosphere high in oxygen since oxygenation of the blood can take place in part through his thin skin. When respiration is established, the infant should be placed in a heated bed to avoid any fall in his body temperature, since a greatly reduced temperature tends to increase the mortality of premature infants. Once the initial inspiration has been taken, any subsequent failure of respiration necessitates less pressure for its re-establishment and is within the ranges of any standard resuscitator.

Although these infants may have a poorly developed thermoregulating center, they definitely have little body fat with consequent poor insulation and they cannot perspire sufficiently to get the cooling effect of evaporation. The absence of these two physical mechanisms contributes toward the instability of body temperature of these infants.

The necessity for insulation of the infant can be realized when it is recalled that a three-pound infant will raise the temperature of an insulated chamber approximately eight degrees of temperature. Conservation of this temperature is im-

portant since its loss is energy loss to the infant. On the other hand, its dissipation is essential in excessive environmental temperatures to prevent a rise in body temperature. Since the infant has little means of dissipating this heat, it is essential that the environmental temperature be regulated to the degree which will maintain the body temperature within a normal range. Fluctuation in the environmental temperature results in energy expenditure to raise or lower the body temperature. Since the infant's energy store is low, it must be conserved. Temperature regulation, therefore, is one of the methods of conservation. With close temperature control alone cyanotic attacks become less frequent.

High humidity in the environmental air is another conservation measure. Since expired air is always 100 per cent saturated with water vapor, the difference between the humidity of the inspired and 100 per cent must be made up by the infant's water stores. Additionally, it is easier to transmit heat to the infant in wet air even though the coefficient of heat transfer is not strikingly different in wet and dry air. Nevertheless, an infant in a relative humidity of at least 65 per cent can be maintained at normal body temperature in appreciably less heat. Humidities of less than 60 per cent are of little assistance in reduction of the required environmental temperature.

High oxygen concentration is a further means of conserving energy. Since the newborn animal of any species is less susceptible to oxygen poisoning than is the adult, higher concentrations are tolerated better by them. Wilson's group has recently shown that the best results in premature infants are to be expected in concentrations of nearly 100 per cent oxygen. This has been our experience also, as mentioned by Stadie in his review of oxygen therapy. Before Wilson's work, 65 per cent was considered the maximum concentration for the species in general. The importance of oxygen is fairly obvious. Since the infant's tidal air is so low, the more of it that he can utilize the more efficient the breathing and the less effort expended.

This low reserve of energy corresponds to his low reserves in calcium, iron, blood protein, and his other body constituents. Because of these low stores he requires vitamin C especially as an essential to the building up of them. Vitamin D is his next most important vitamin. Iron is not

well enough assimilated to be worth administering until he is approximately five pounds in weight, so transfusions should be relied upon for antianemic therapy and support.

Besides conserving the energy of the premature infant, he must be protected against infection. He is susceptible to invasion by micro-organisms which he may inhale from the air, to those acquired from contact with contaminated hands and articles, as well as to those which may enter him through his food or needles.

It is necessary, therefore, to be certain that the air he breathes is not carrying pathogenic micro-organisms, that great care is exercised in keeping clean the hands which are to touch him, that his formula is carefully sterilized, and that anything which can be administered to him by mouth is given him by this route in order to avoid the trauma and possible infection risked with needles.

The care of the premature infant then may be stated as the recognition of the physiologic bases from which his difficulties may arise and the application of measures to assist him in overcoming his deficiencies. These measures vary only in degree from those applied in the care of the full-term infant.

In the newborn infant, whether born prematurely or at term, one should consider the possibility of congenital defects. Most of these are obvious at a glance, but there are many exceptions. A congenital heart defect may not manifest itself immediately. Bowel atresias and imperforations are not seen on inspection. Tracheo-esophageal fistulas are not obvious at a glance, but they occur, in some reported series, with the same frequency as harelip. Because of the uncertainty of the presence of these abnormalities, the prognosis is not entirely clear in the immediate postpartum period.

The signs by which they are recognized cannot all be discussed here, but a few of the commoner conditions which are less well recognized may be mentioned. The first of these is tracheo-esophageal fistula. Its frequency demands that the first feeding of a baby should be sweetened water in order that milk should not be introduced into the lung if the defect should be present. Cyanosis or râles following swallowing suggest its presence. A catheter in the esophagus establishes its existence if an obstruction is encountered. Treatment is effective in the hands of a capable sur-

geon when operation is accomplished within a short interval after birth. Few indeed have survived when the operation was delayed until the fifth day of life.

Orthopedic deformities, too, should be treated very early. The most common of these is club-foot. This responds quickly to overcorrection applied within a few days of birth except in the rare instances when extensive bony deformity exists. Whether this is or is not present can be detected with certainty within the first five days of life. Thereafter the inelasticity of the capsule may mislead one into the belief that the defect is more extensive than is really the case.

Certain other orthopedic defects may be present but inapparent. A means of detecting them lies in the determination of the infant's position of greatest comfort. The newborn infant is most comfortable in the position to which he became accustomed during intra-uterine life. Then he was closely confined in an average of less than 1000 cc. of amniotic fluid, his motions were limited, and he frequently became caught in what (to us) appear to be most uncomfortable arrangements of the extremities. In order to adapt, his joint capsules relaxed with resulting subluxation of those joints which resisted too greatly the encroachment of the uterine wall.

After his birth he retains considerable elasticity of all joints for a few days. Then those joints which were excessively relaxed become stiff. In most joints so involved this stiffness is overcome in a few months. In the hip and in the jaw, however, the influence of pressure on bone formation is likely to be added to the stiffness and result in a more permanent, or serious, condition.

In the hip, because of the flexed thigh, an excessive relaxation of the capsule denies the joint the stimulus of pressure to cause it to ossify. It remains in the fetal cartilaginous state which is too soft to resist dislocation when the child stands. Thus "congenital dislocation of the hip" is not congenitally dislocated but is simply a persistence of the soft, cartilaginous fetal hip. It is recognizable in early infancy by a simple maneuver. The examiner simply lays the infant on its back and abducts the flexed knees. Utilizing the vulva or the median raphe as a perpendicular, the abduction for each thigh is noted. When this is appreciably less than 80 degrees (the normal infant's knees can be passively abducted nearly to the table), the presence of a cartilaginous hip

should be suspected. A roentgenogram will definitely establish its existence. The x-ray signs, like the physical, are based on the absence of ossification and *not* on dislocation, which is seldom present. The acetabulum on x-ray shows, normally, a well-defined outer margin. Roundness, softness, or concavity at this critical location is evidence of an instability of the hip even though no dislocation whatever is evident on the film.

When this condition is suspected, treatment should be instituted. This statement is possible because treatment in the first few weeks of life can consist only of pinning the infant's diapers to the bed, for a few hours each day, in order to maintain effectively the abduction required to permit the femoral head's straight pressure into the acetabulum with consequent rapid ossification of both cartilaginous structures. Pinning is most efficiently accomplished with the infant prone. A safety pin should hold the diaper above each knee to the sheet, with a third pin to secure the seat of the diaper in order to prevent his working up toward the head of the bed. The baby's body weight then increases the abduction until it is complete. Within a few days the infant has accepted this position as his habitual sleeping posture and this painless therapy can continue indefinitely.

If diagnosis is delayed until after 2 months of age, physical therapy to relieve the abductor spasm is required before abduction can be accomplished. Diagnosis made after 5 months of age is late and the treatment required is proportionately extended and uncomfortable. Early diagnosis and institution of therapy mean that the infant will not be uncomfortable, activity will

not be limited, and walking without a limp will be assured at the normal walking age.

This is most important because even its severe form, "congenital hip," is far from rare. In its less severe form, subluxation, it is common, although frequently real symptoms do not appear until about 35 years of age. It occurs in Anglo-Saxons with much greater frequency than among the Italians, in whom it was thought to be most common. It is rare only in Negroes. Its recognition is accomplished through an exceedingly simple maneuver, its treatment when instituted early is painless and short, and its prognosis is excellent. Delay in diagnosis reverses both the last points.

Summary

The premature infant has a friable brain and tendency to hemorrhage, making him vulnerable to trauma. His soft rib cage and few pulmonary alveoli make respiration difficult to initiate and maintain. His blood-forming organs are immature, and his mineral and vitamin storage is low. He cannot stabilize his body temperature, and he is extremely susceptible to infection.

The full-term infant has fewer problems, but resuscitative and protective measures are important for him, too.

Either group may have apparent or inapparent congenital defects at birth.

Methods for resuscitation, for protection, and for recognition of inapparent defects are discussed. One of the most important of these is "congenital hip." This is diagnosable in earliest infancy with a simple maneuver. Its treatment at this age is short and comfortable to the infant and its prognosis is excellent.

The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals.—Section 1, Chapter 1, Principles of Medical Ethics of the American Medical Association.

MITRAL STENOSIS

Its Surgical Treatment by Commissurotomy

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WITHIN the past few years an intense and widespread interest in the surgical treatment of certain cardiovascular disorders has been engendered by the epochal contributions of Blacklock, Taussig, Gross, Crafoord, Potts, and others. Their efforts have focused attention primarily upon the problems of congenital heart disease. Their methods of surgical correction of these anomalies by "extracardiac" procedures have been adopted and standardized throughout the world. Concomitant with these developments, Smithy, Harken, Murray, the authors, and others have in turn been concerned with the surgical alleviation of an even more important group of cardiac diseases, for the most part acquired but which require an "intracardiac" approach for their relief. It was inevitable, therefore, that chronic valvular disease, especially structural stenosis of the mitral valve, would attract the initial attention of these investigators.

The prognosis of an individual case of mitral stenosis depends upon many factors: the age of the patient, the severity of the lesion, the presence or absence of other valve defects, the presence or absence of additional rheumatic activity, and the condition of the myocardium. The ultimate outcome, however, is almost invariably unfavorable once the stenotic change gives rise to a progressive pattern. Thus, when the diagnosis of early mitral stenosis has been established, the cardiologist can picture and predict with considerable accuracy, both by repeated physical examinations and observance of the patient's general condition, the structural and symptomatic phases through which a given case will pass. His treat-

ment will at once be directed toward the prevention of further rheumatic insults and the support of a heart muscle which is attempting to maintain adequate systemic circulation in the face of an increasing mechanical stricture. Under such circumstances both the cardiologist and the myocardium are fighting a losing battle. It is little wonder, therefore, that in his deliberations Sir Lauder Brunton,¹ as early as 1902, concluded that direct surgical incision of the stenotic valve provided the only logical method of interrupting the relentless chain of events attendant upon progressive mitral stenosis.

Pursuing this line of reasoning, there followed years of sporadic research, both experimental and clinical. Early investigation was concerned with an experimental production of mitral stenosis and insufficiency, providing material for the study of physiologic pressure changes so produced.^{2, 3, 4, 5} Although, even to this day, true mitral stenosis simulating the clinical form of the disease has never been duplicated, cicatricial constrictions of the mitral ring have provided a medium for the thorough evaluation of obstructive phenomena upon the pulmonary circulation and right side of the heart. By 1929 Cutler and Beck⁶ were able to collect ten cases from the literature in which surgical relief of mitral stenosis had been attempted. These efforts in the main had been made by the introduction of punch-like instruments through the myocardium of the left ventricle blindly engaging upon a mitral valve cusp with the removal of portions of tissue, thereby enlarging the valve orifice but converting a lesion primarily stenotic into one primarily regurgitant. That this was poorly tolerated is evidenced by the fact that only one of ten patients survived, and thus all surgical attempts fell into disrepute until very recent years.

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Powers,^{7, 8, 9} in 1932, demonstrated, again experimentally, that the abrupt conversion of mitral stenosis to mitral regurgitation with its sudden overwhelming increase in pulmonary congestion was responsible for the fatal outcome in cases so treated. This knowledge has prompted more recent investigators to direct their attention to relief of stenosis by producing either small amounts (controlled) of regurgitation or, more ideally, no additional regurgitation at all. In addition, methods of grafting body tissues into the cardiac chambers to replace deformed valves have been devised, but as yet have not been sufficiently perfected to warrant general usage.^{10, 11} Thus since 1929 fourteen additional attempts (not including our own) to relieve mitral stenosis by various punch or plastic procedures upon the valve itself have been made.^{12, 13, 14, 15} Nine of these patients survived the operation, but a number have since died as a result of induced, though possibly limited, mitral insufficiency. It is obvious, therefore, that future efforts must be directed at the relief of stenosis without the production of significant regurgitation if long-lasting benefits are to be derived from surgical intervention.

The purpose of this communication is to present a method for the relief of mitral stenosis whereby the production of regurgitation has been so minimized as to be not significantly greater than that which inherently exists with all mitral stenosis, by its very nature. Should this method continue to prove practical, it will become incumbent upon the cardiologist to classify and re-evaluate mitral stenosis on a more exacting physiologic basis so that proper selection of cases for surgical intervention may be forthcoming. For this re-evaluation the work of Cournand¹⁶ and Bing¹⁷ has been outstanding and their methods of thorough study must be more generally utilized.

Careful clinical examination and appraisal by an experienced cardiologist is obviously essential. His armamentarium has long included, in addition to subjective and auscultatory analysis: (1) electrocardiograms and sound recordings; (2) teleroentgenograms, esophagograms, and fluoroscopy for an estimation of the size of individual heart chambers; (3) exercise tolerance tests; and (4) laboratory data for the detection of rheumatic activity. Such a program has been the standard means of determining the presence and the course of the disease as well as the benefit derived from therapeutic measures. To this now

must be added procedures for the detection of early physiologic changes. To evaluate cases for surgical intervention, there must be included (5) estimations of cardiac output at rest and with exercise as calculated by ballistocardiography or, more accurately, by utilization of the Fick principle; and (6) determinations of the pulmonary arterial and right ventricular pressures by cardiac catheterization.

The value of the first four methods is unquestioned when carried out by experienced clinicians, even though many minor individual variances may emphasize one finding rather than another. In many cases, however, the conclusions drawn from this type of evaluation alone may be dependent upon the presence of advanced pathologic changes. Significant pathologic and physiologic changes may well be detected earlier by more recently developed methods (5 and 6 above) and point the way toward reconstructive surgery before irreversible changes have occurred.

Anatomic, Pathologic, and Physiologic Considerations

The interplay of these three factors with reference to the mitral valve, when reduced to essential components, is readily understandable.

The normal mitral valve may be likened to a truncated cone of thin, flexible membrane. Its base is attached at the left atrioventricular ring, and its apex extends into the left ventricle. The apex and the outer surface of the apical half of this cone are suspended by numerous "guy wires" (chordae tendineae) attached to papillary muscles arising from the ventricular wall near the ventricular apex. The chordae tendineae are grouped more heavily in two areas of the mitral apex, at either side. These areas represent the anatomic fusion of the two components of the valve (an anteromedial and a posterolateral leaf), and represent the corners of the apex upon which the leaves fold themselves. The apical portion of the valve cone is somewhat folded or flattened upon these points. When modified by rheumatic disease, these points of folding become the "commissures." The plane of flattening is oblique (with the patient in the supine position), running from the left anterolateral portion of the valve posteromedially. The anterior or anteromedial valve cusp is larger than the posterolateral, and is continuous with the posterior portion of the intracardiac aortic wall. During auricular

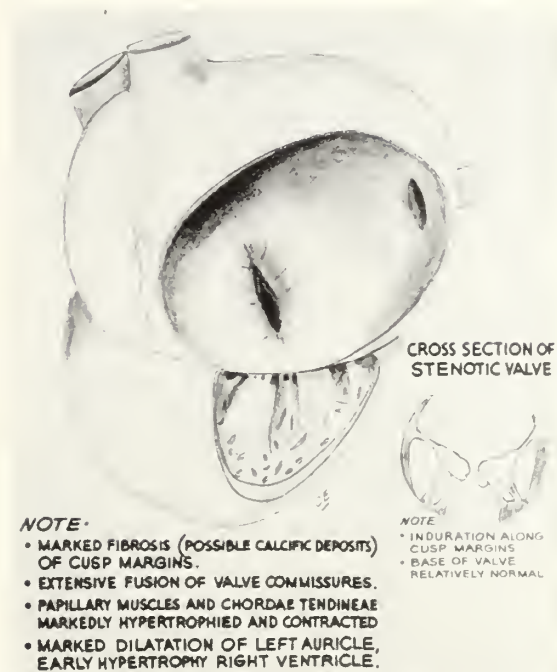


Fig. 1. Pathologic changes in late mitral stenosis. Note that the base of the valve remains thin, pliable, and relatively normal.

systole the posterior or posterolateral cusp lies well away from the ventricular wall. During ventricular systole the ventricular wall may approximate and support it. Thus mitral regurgitation is primarily a defect or dysfunction of the anteromedial valve cusp. A defect of the posterolateral cusp produces only "limited regurgitation" rather than the uncontrolled reflux of blood, as seen when a defect in the continuity of the anteromedial cusp prevents normal deflection of the ventricular output into the intracardiac aorta. The papillary muscles contract synchronously with the ventricle, drawing the chordae tendineae taut, thus preventing the valve leaflets from becoming inverted or displaced backward into the auricle.

In rheumatic disease the mitral valve develops numerous minute cauliflower-like vegetations (1-2 mm. diameter) in a row along the line of closure of the valve. Healing leads to the formation of scar tissue. With repeated infection and healing, there is gradual development of fibrosis, thickening, narrowing, and shortening of the apical portion of the valve cone. This scarring and narrowing may be very limited in extent to merely resemble a purse-string puckering of the valve orifice. In other instances, the disease involves one-quarter to three-quarters of the cone, leaving a flexible margin along its base (Fig. 1).

In far-advanced disease the whole valve becomes a rigid, completely inflexible, often calcified structure resembling a hard ovoid plaque surrounding a small fish-mouth slit. Most physicians and even many pathologists think of such extreme deformity as classical and the rule in mitral stenosis. We have found this condition in only one of our 16 cases.

Usually mitral rheumatic disease hardens or fixes the apex of the mitral cone in the infolded or flattened position so that the commissures become an anatomic reality. Thus mitral stenosis is produced, offering marked resistance to the passage of blood from the left auricle into the left ventricle. Some degree of regurgitation through the mitral slit during ventricular contraction is common. Not infrequently mitral rheumatic disease hardens and shortens the valve cone to a point where the leaves cannot be approximated. Such cases of predominant mitral regurgitation are less common than those predominantly stenotic, and at the present time are not amenable to surgical correction.

Mitral stenosis of any degree interferes with filling of the left ventricle, and thus with the maintenance of normal systemic cardiac output. Many such hearts are unable to increase their output over and above resting bodily require-

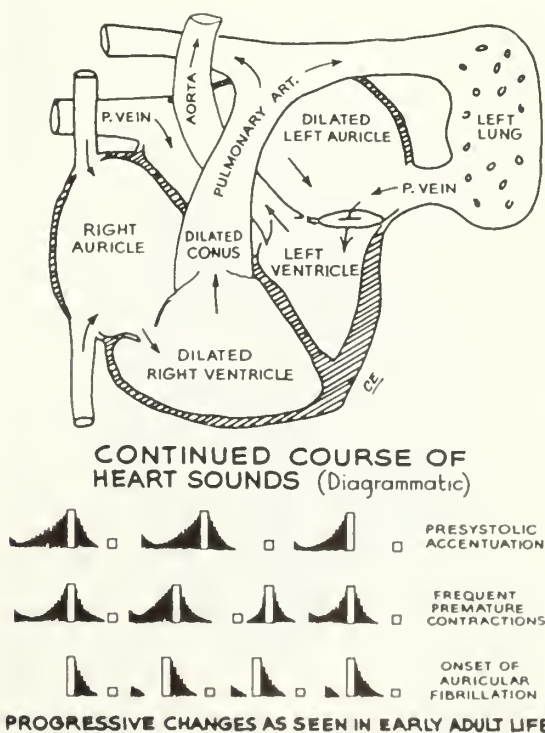


Fig. 2. Physiologic changes (progressive) during late stages of mitral stenosis.

ments. Thus any appreciable amount of work will quickly cause patients with such hearts to become fatigued, dizzy, and even momentarily to lose consciousness. Concurrently, since the egress of blood from the left auricle is impaired, increased pressure within and great dilatation of this chamber result. The high intra-auricular pressure is transmitted to the entire pulmonary vascular system and thence to the right ventricle (Fig. 2). A chronic pulmonary hypertension ensues, with nocturnal or exertional pulmonary edema (dyspnea), rupture of pulmonary capillaries (hemoptysis), and failure of the right side of the heart (enlarged liver, ascites, and peripheral edema).

Surgical Considerations

The possible surgical approaches to the problem of mitral stenosis seem to take one of the following three courses:

1. Methods of by-passing the stenotic mitral valve.
2. Methods of relieving the associated pulmonary hypertension.
3. Methods of direct surgical attack upon the stenotic valve.

The first two methods of surgical approach have been reviewed in two previous communications^{18, 19} and will not be repeated here. It is sufficient to state that methods of by-passing the stenotic valve have as yet been carried out only on an experimental basis and are not sufficiently developed to warrant clinical trial. Methods of relieving the associated pulmonary hypertension by producing a shunt between the pulmonary and systemic venous systems, although of some merit, seem to be of such a palliative nature only that no long lasting benefit can reasonably be derived by the patient and are, therefore, undesirable provided direct and successful attack upon the damaged mitral valve can be accomplished.

As to the third method of surgical approach, since the first section of the mitral ring by Elliott Cutler²⁰ in 1923, there have been a number of direct attacks upon the stenotic mitral valve. The approach and the methods employed have varied. The left auricular appendage as a site of entrance has been utilized by Allen and Graham,^{21, 22} 1923; Souttar,²³ 1925; the authors, 1945; Smithy, 1947; and Harken, 1947; the left ventricle by Cutler, Levine, and Beck,²⁴ 1924; Pribram,²⁵ 1925; and through the left pulmonary

vein by Harken in 1946. It is our considered opinion that the approach through the auricular appendage is far superior to any other. It leads directly into the wide opening of the mitral funnel and thence to its stenotic orifice. There are no chordae tendineae to interfere with the passage of the instruments or finger. In addition, no serious disturbance of cardiac rhythm or function is produced. The finger or instrument is well tolerated in the roomy left auricle, unless the actual passage of blood into the ventricle is obstructed for more than three beats. In addition, the appendage may be readily and securely ligated at completion of the operation.

On the other hand, the left ventricular approach is obstructed by chordae tendineae and does not insure ready or accurate localization of the small opening of the mitral funnel. Such an approach may provoke a serious arrhythmia, does not permit digital insertion or palpation, and may be difficult to close securely.

Simple incision of a mitral valve cusp has a very deleterious effect upon the experimental animal. If the anteromedial or "aortic" cusp of the mitral valve is completely divided, death is prompt and almost immediate. If the posterior cusp is completely divided, death is usual within 24 hours. Although Cutler's first case lived 4½ years after simple incision, it appears that he did not completely divide the cusp. Dogs, too, will tolerate lesser degrees of valve section. One of the objections to simple incision of the ring is the possibility of healing at the site of the incision. It seems improbable that such healing would occur if the valve ring were widely incised, since the edges would then gape widely during most of the cardiac cycle. On the other hand, if the incision only extended partially through the scar tissue, it could not gape and very probably healing and further cicatrix would occur. We have never observed healing in an adequately incised heart valve in dogs followed for periods up to twelve months or in one human case three months postoperatively. Of three such patients reported by Cutler, Levine, and Beck, two died shortly after surgery.

Simple excision of the valve ring was practiced by Cutler and Levine²⁰ in 1923, and by Cutler, Levine, and Beck, also by Pribram, and later by Smithy. Since it was felt that the only hope in mitral stenosis was to replace it by a regurgitant type of lesion, partial excision of the valve orifice seemed to be a logical procedure. We are un-



Fig. 3. Commissurotomy knife inserted between two gloves on the palmar surface of the right index finger.

equivocally opposed to this concept, since experimentally and clinically it has been demonstrated that a suddenly produced mitral regurgitation is poorly tolerated and is as serious a lesion as the original stenosis. Results by this form of treatment have been discouraging in the past. Four patients so treated by Cutler, Levine, and Beck, and one by Pribram, all died within six days after operation. Smithy reported five living patients out of seven such operations in June, 1948. His better results may be attributed partially to advances in anesthesia and surgery since the work of the 1920's. More pertinent, however, is the fact that by design he excised relatively small pieces of valve tissue. Time will supply the answer as to how well his patients will carry on with their superimposed though limited regurgitation.

Digital dilatation of the stenotic valve was first practiced by Souttar in 1925 with success in one case. We have since performed three such dilatations with one success. The first of these was done on June 12, 1946. A very hard calcified valve slit in a practically moribund woman was dilated with marked temporary improvement. Death within three days was disclosed at autopsy to be due to clotting at the torn commissures. It was evident that the valve had torn at the line of the commissures sufficiently to establish some temporary valve function. Thrombosis had quickly re-established or increased the stenosis, causing death. During the postmortem examination the idea of cutting the commissures well into normal valvular tissue under direct digital

guidance or "vision" was born. Since that time we have had to resort to simple digital dilatation in two additional cases. We are well aware from studies of stenotic mitral valves incidentally found at autopsy that simple digital dilatation does not always result in tearing the fused fibrotic commissures. The ring tears at its weakest point, which may well be across a cusp. Even when the tearing does occur at the commissures, one finger is seldom large enough to force the tearing to extend beyond the fibrotic tissue into normal valve structure. However, this early case of dilatation did result in what we then considered to be an entirely new concept of treatment.

Harken has used the term "valvuloplasty" to describe his procedure of resecting portions of the valve ring at the commissures. He rightly recognizes that resection will best be tolerated if performed at the commissures, assuming that resection with limited or selective regurgitation is the desired result. Two such operations have been performed. In one the pressure in the left auricle was 450 mm. (water), but rose above the reading of a 500 mm. manometer after valvuloplasty of this type. This was attributed to a coincident tachycardia. The patient died in pulmonary edema 24 hours later. In the other patient, left auricular pressure dropped from 450



Fig. 4. Diagrammatic representation depicting position of commissurotomy knife incising anterolateral commissure well into normal valve tissue. The stroke of the knife is made with the left hand on the handle of the knife while the index finger of the right hand remains in situ.

mm. (water) to 400 mm. (water) during the procedure. He was improved subjectively. Localization of the commissures was accomplished by palpating the valve with the valvulotome inserted through the auricular appendage.

Commissurotomy is a term suggested to us by Dr. Thomas Durant of Philadelphia to designate the procedure which we have employed to re-establish a marked degree of normal mitral valve

function. Our present operative technique is simplified and direct. With the patient in the supine position, the left arm over the head, an incision is made over the left third rib or in the inframammary fold. The third rib is removed, including the costal cartilage. The cartilages of ribs two and four may be divided. The pleura is opened through the incised rib bed. The lung is permitted to collapse. The pericardium is incised

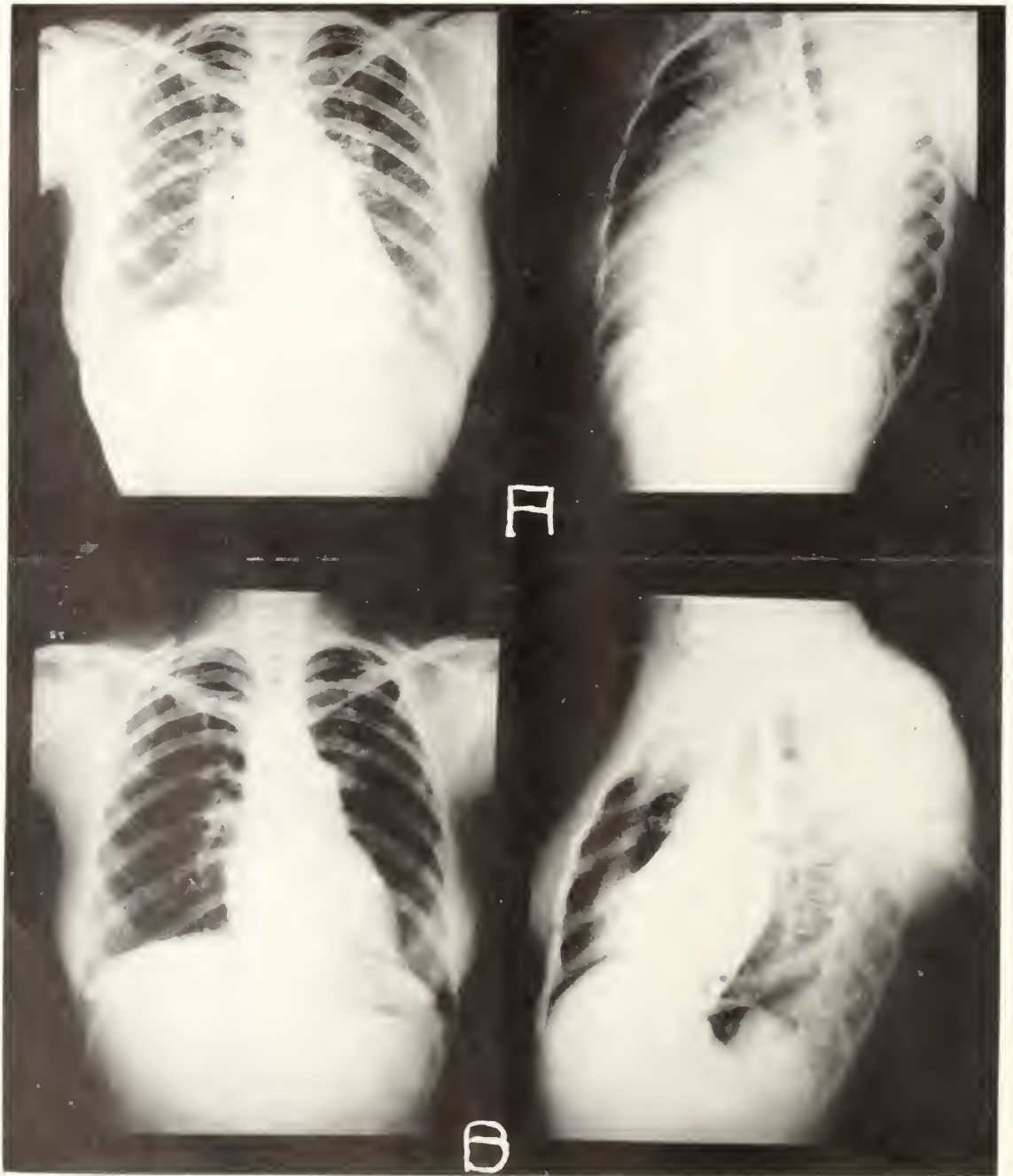


Fig. 5. (A) Postero-anterior and right anterior oblique roentgenograms showing size of heart and left auricle preoperatively (case 5). (B) Postero-anterior and right anterior oblique roentgenograms showing reduced size of heart and left auricle and decreased pulmonary vascular congestion six months postoperatively (case 5).

longitudinally, one-half inch anterior to the phrenic nerve, for three inches. Care must be taken not to extend the incision too far toward the apex, lest the heart have a tendency to herniate from its sac. The huge distended auricular appendage now protrudes. The pericardial sac is sprayed with 5 per cent procaine and additional procaine is injected under the epicardium encircling the base of the auricular appendage (at the suggestion of Smithy). A purse-string suture of heavy braided silk on an atraumatic needle is passed about the appendage through this injected area. A Satinsky clamp is now closed over the base of the appendage and a generous portion of its tip is amputated. This piece serves for heart muscle biopsy.

All intra-appendageal trabeculae that might interfere with insertion of the finger are divided. Two gloves are worn on the right hand. An opening is made in the outer one on the palmar surface at the base of the index finger, and another at the tip. The blade of the commissurotomy knife is inserted between the gloves (Fig. 3) on the index finger, and the finger is inserted into the left auricle as the clamp is released. The finger is well tolerated by the auricle and causes no disturbance unless the mitral opening is actually obstructed by the finger tip for several beats. The valve is easily located, and is explored. Its structure is estimated and the size of the opening and the location of the commissures are determined. The knife is now protruded through the orifice and the hook is engaged upon

the anterolateral commissure (Fig. 4). A backward stroke divides the commissure, usually adequately the first time. The finger again palpates the opening and gently dilates it.

Sometimes there are remaining fibrous strands which require either digital separation or actual division with the knife. If the cut in the commissure does not extend well into normal tissue, it is repeated. In cases which have a rather soft valve orifice markedly diminished in cross-sectional area, simple opening of the lateral commissure is in our opinion sufficient. On the other hand, with a rigid, fixed, and sometimes calcified valve, incision of only one commissure would undoubtedly be inadequate. In such more advanced cases we reinsert the knife through the orifice by simple pronation of the hand, bringing the blade into apposition with the posteromedial commissure, which is then divided.

Having inserted the finger once more through the enlarged opening to make sure of its mobility and function, the finger and knife are deftly withdrawn from the auricle. The previously placed purse-string suture is drawn tight, preventing more than a few cubic centimeters of blood loss. The suture is tied, and the cut edge of the appendage is oversewn. There should be no disturbance of the systemic circulation and few irregularities throughout the procedure. The pericardium is left open and the pleura is drained. The chest wall is closed in layers.

Postoperatively, the patient may experience considerable pain for three to four days from the "chemical" pericarditis produced by manipulation. This is controlled by opiates. Ambulation is permitted within two to five days.

It is our present belief that commissurotomy by such a technique is a simple, relatively safe, direct method of re-establishing improved valve function. It has the great advantage of direct digital guidance. It should not, and has not in any of our five successful cases, produced any detectable amount of mitral regurgitation. Blood loss is minimal and no apparent disturbance to heart function results. That it effectively accomplished the desired result is shown not only by the marked clinical improvement in all living patients but also by objective physiologic studies.

Table I reveals the pressure changes observed in one of our cases studied before and after commissurotomy. The pressures in the left auricle were taken directly with the heart exposed immediately before and immediately after cutting the

TABLE I

CARDIAC CATHETERIZATION

(J. B., Age 32, Case 6)

<i>Preoperatively</i> (1/21/49)	<i>Systolic</i>		<i>Diastolic</i>		<i>Pulse</i>
	<i>Max.</i>	<i>Min.</i>	<i>Max.</i>	<i>Min.</i>	
Right pulmonary artery					
Main pulmonary artery					
Right ventricle	96	83	20	14	85
Right auricle	17	9	5	1	83
<i>Postoperatively</i> (3/3/49)					
Right pulmonary artery	49	41	16	..	80
Main pulmonary artery	51	48	16	..	80
Right ventricle	49	40	3	—3	72
Right auricle	10	6	3	1	?

COMMISSUROTOMY 2/2/49

	<i>Left Auricle</i>		<i>Pulse</i>
	<i>Systolic</i>	<i>Diastolic</i>	
Before commissurotomy ...	45	30	90
After commissurotomy	15	3	96

valve. In none of these cases was there any appreciable blood loss, significant change of rate or rhythm, or disturbance of systemic circulation. We believe that these changes in the left auricular pressure indicate two things: first, the mitral stenosis was at least partially relieved or pressure would not have fallen; second, no appreciable increase in pre-existing regurgitation was produced or the pressure would have risen.

Long-term follow-up alone can supply the ultimate answer as to the effectiveness of commissurotomy. Nevertheless, since years must elapse for such information to become available, we feel justified in proceeding in those cases which meet our present rigid indications and in which it might be life-saving. In this our thinking follows the line already established by Blalock and Tausig with regard to their work on pulmonary stenosis. The day will undoubtedly come when an extracorporeal circulation will permit exclusion of the heart and lungs from active duty during intracardiac surgery. At that time it will be possible to open the heart widely and perform plastic procedures upon the valves and septa under direct vision. Such operations as commissurotomy will then become antiquated.

Results

Our early results with procedures other than commissurotomy were most discouraging, but with improved selection of cases and improved technique they have begun to show promise. A summary of our entire experience to date has been published elsewhere.^{18,19,26}

Commissurotomy by the technique described was performed in eight cases with three fatalities (Table II). In the first of these (case 1) a modified scalpel was employed, as our present commissurotomy knife had not been perfected. Attempts to incise the commissure were attended by repeated disengagement of the blade as it rode over the fibrotic valve, resulting in an inadequate incision extending only a few millimeters into the scar tissue. Pre- and postoperative pressure determinations in the left auricle were unchanged (320 mm. water). The patient died on the sixth postoperative day in pulmonary edema from unrelieved mitral stenosis. The second patient (case 4) was operated upon accurately and well, and appeared to be on the way to a most satisfactory result, but suffered a cerebral embolus and died suddenly on the seventh postoperative day. Autopsy disclosed an adequate and satisfactory commissurotomy. Thrombus formation had occurred in the left auricular appendage, from which the embolus apparently originated. We have observed such thrombus formation many times in animal appendages after valve surgery, but no adverse complications resulted. We had simply oversewn the incision in the appendage at the conclusion of the procedure. In six succeeding cases (and in a previous one (C. W.) without purposeful design) we ligated the auricular appendage at its base to prevent such disaster. The appendage of the third patient operated upon shortly thereafter was ligated at its base without suture of the cut tip. Autopsy indicated that hemorrhage had occurred from this

TABLE II
COMMISSUROTOMY IN MITRAL STENOSIS

<i>Case Number</i>	<i>Patient</i>	<i>Date of Operation</i>	<i>Type of Operation</i>	<i>Result</i>
1	W. W. Age, 39	3-22-48	Commissurotomy	Death in 6 days—technical difficulty
2	C. W. Age, 24	6-10-48	Commissurotomy	Living—excellent result
3	S. S. Age, 35	6-27-48	Commissurotomy	Living—excellent result
4	F. G. Age, 35	7-13-48	Commissurotomy	Death in 8 days—sudden cerebral embolus
5	A. W. Age, 35	9-2-48	Commissurotomy	Death in 24 hours—hemorrhage
6	J. B. Age, 32	2-2-49	Commissurotomy	Living—excellent result
7	S. C. Age, 21	3-23-49	Commissurotomy	Living—excellent result
8	E. W. Age, 32	4-20-49	Commissurotomy and dilatation	Living—improved

site (case 5). This experience led to both ligation at the base and an oversewing suture at the cut tip in all subsequent cases.

The remaining five cases represent most satisfactory results. Four patients are clinically well. Two who had been digitalized for some months prior to surgery no longer require such medication. There is definite diminution in the size of the heart as shown roentgenographically (Fig. 5, A-B). Their tolerance for exercise is remarkably increased, permitting them to return to normal activity. Careful examination reveals some slight residual evidence of mitral stenosis in two of the patients (cases 2 and 6) and somewhat more in a third (case 8) in whom conditions were not satisfactory for an ideal commissurotomy. The others seem to have no residual signs of the disease, although they are admittedly short-term follow-ups. Electrocardiographic follow-up shows no significant change from the pre-operative state. There has been no evidence of increased mitral regurgitation in any of the five.

Indications and Contraindications for Surgery (at Present)

The indications and contraindications for commissurotomy must be considered together. Both must change as experience dictates. Common sense and our present experience have led to certain conclusions to date:

1. *Most favorable group.*

- A. Excessive fatigability.
Increasing exertional dyspnea.
- B. No rheumatic activity.
Normal sinus rhythm.
Lesion predominantly stenosis.
Evidence of significantly increasing pulmonary hypertension.

2. *Less favorable group.*

The above plus:

- A. Recurrent bouts of hemoptysis.
- B. Arterial embolic phenomena.
- C. Auricular fibrillation without failure.

It follows then that our contraindications would be:

- 1. Active rheumatic infection.
- 2. Presence of superimposed subacute bacterial endocarditis.
- 3. Cardiac failure uncontrollable by medical means.

- 4. Presence of marked associated mitral regurgitation or other valve (aortic) deformities.

Summary

Our entire experience with surgery for mitral stenosis (16 cases) has been reviewed. In eight, commissurotomy was performed with four satisfactory results, one fair result, and three deaths. Had our present knowledge been applied to all cases, the mortality might have been appreciably lowered.

Commissurotomy is a simple, direct, effective, and safe procedure. Its exact surgical technique has been outlined.

Commissurotomy accomplishes relief of mitral stenosis by restoring considerable valve function without the production of additional mitral regurgitation.

Digital guidance in the performance of accurate valve surgery is essential until a method of direct vision becomes established.

The left auricular appendage is the most satisfactory avenue of approach to the mitral valve.

The auricular appendage must be ligated at the conclusion of the procedure to prevent arterial embolization. This may prove to be the proper approach to the management of arterial embolization in many cases of auricular fibrillation unassociated with mitral stenosis.

An appreciably enlarged left ventricle in a case of supposed "pure" mitral stenosis is indicative of some additional significant valve lesion (aortic stenosis or regurgitation, or mitral regurgitation) and is probably contraindicated to commissurotomy at the present time.

Study methods of value in addition to clinical evaluation embrace cardiac catheterization for determination of pulmonary vascular pressure, ballistocardiography, and other physiologic studies for the determination of cardiac output.

Venous shunts for the treatment of mitral stenosis are of limited and palliative value only. Their eventual effects upon cardiac output, the right ventricle, and the lesser circulation must be kept clearly in mind.

(Twenty-two additional cases of advanced mitral stenosis have undergone commissurotomy since this paper was submitted for publication, bringing the total series to thirty. There have been six deaths. In 21 of the 24 living patients the results have been very satisfactory to date, both subjectively and by objective improvement similar to that shown in Table I. In three, improvement has been considerable subjectively but less striking objectively.)

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A NEW SONG

The American Medical Association, in the report of its National Education Campaign of 1949, refers to the fees paid for membership in various typical organizations of a different nature. These range from \$35 collected by the executive leaders of the purchasing agents, through the \$45 assessment on architects and the \$75 annual levy of the local teamsters' unions to the \$150 required from the American retail jewelers. Political, educational, and other campaigns come extra and come high. It is made apparent that the physicians of the country are being called upon for a small contribution compared with the organizations listed, although no statement appears regarding state and local societies or special colleges, academies, and boards for the support of which these laborers in their particular vineyards may be liable.

It is unfortunate that there should seem to be a necessity for any comparison between the American Medical Association and some of the groups mentioned—between a professional association established for service to the people and the organizations of the motion-picture operators, the purchasing agents and the teamsters, worthy as these fraternities may be. They are organized, it happens, for quite a different purpose.

Educational programs—program is a better word than campaign, which implies a special effort eventually to be concluded—are a necessary part of modern life. They are concerned with that perpetual requirement of gregarious living on which so much emphasis is being

placed in these present piping times—better human relations.

Educational programs, however, must be consistent. They must tell, if not the whole truth, at least a large part of it, and no untruths. They must reveal the faults in human conduct as well as its virtues; its failures as well as its successes.

Satisfactory human relations have always been difficult but rarely impossible to attain. They have been the reward of a superior degree of candor, an ability to see all sides of a controversial matter and the capacity for free and friendly discussion regarding it.

There is much ground to cover if people are to become even a little better adjusted to each other than at present, for they are living in a period of more than usual strain and stress. They are living in the midst of increased racial and religious and other social prejudices, and of economic and political uncertainties.

The profession of medicine, with so much in its record to recommend it, has nevertheless much that can be improved in both the quality and the distribution of its service. The more that is told of its story and the greater readiness there is to establish mutual understandings, the better will relations become. The second half of the century must be more productive in this respect than was the first.

A recurrent theme of the Psalms of David—"I will sing a new song unto thee"—might also represent a turning point in the public relations of a profession.—*The New England Journal of Medicine*, Feb. 23, 1950.

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EDITORIALS

ALCOHOLISM A PUBLIC HEALTH PROBLEM

Norris H. Vaux, M.D., Secretary of the Pennsylvania Department of Health, has suggested the inclusion of "alcoholism" as a subject for discussion during the 1950 session of The Medical Society of the State of Pennsylvania.

The interest of Dr. Vaux reflects action by the 1949 Legislature requiring the Department to make a statistical study of the subject. This study was recently initiated with the appointment of Mrs. Helen C. Snyder, of Philadelphia, who has had wide experience with the problem.

No appropriation accompanied the provisions of this Act, but Dr. Vaux very wisely believes that its discussion, under the auspices of the State Medical Society, may spread needed professional and public interest and influence future planning.

The Act provides that "The Department of Health shall have the power, and its duty shall be: (a) To investigate the subject of alcoholism in respect to rehabilitation and compile and maintain statistics indicating the effectiveness of any rehabilitation programs carried forward by State-aided clinics for alcoholics, State hospitals,

and State-aided hospitals for receiving alcoholics."

The Governor of Massachusetts, in his recent message to both branches of the 1950 Legislature of that state, stated that its Commission on Alcoholism reported 30,000 alcoholic patients and 90,000 problem drinkers in Massachusetts, and concluded his message with advice to the Legislature that it make provision for the Department of Public Health to cover the cost of establishing alcoholic clinics, including the salaries of personnel furnished under the direction of the State Commission on Alcoholism.

We note in the January-March issue of *Pennsylvania's Health* that the Joint State Government Commission reported "58,000 alcoholics in the Commonwealth" last year, many of whom as chronic alcoholics doubtless received scores of repeated jail sentences in the course of their lifetime at great expense to the taxpayers.

It is hoped that this approach to the puzzling but important medical and public health problem of alcoholism in Pennsylvania may have something aside from the correctional phase, and will receive the support of the medical profession throughout the State.

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

NOTABLE CENTENARY CELEBRATION

The Woman's Medical College of Pennsylvania is currently celebrating its first hundred years of service to God and to mankind.

Its graduates have served as medical missionaries of Christian churches in many foreign lands and as successful practitioners throughout North America. They have been so thoroughly assimilated as fellows in all fields of medical practice as to have been in more recent years elected to high office in component medical societies, in which they serve with distinction equaling that achieved by them in the realms of diagnosis and treatment.

The Medical Society of the State of Pennsylvania has formally extended congratulations and best wishes to the College for a second century of even greater attainments, and at the same time expressed its pride in having enrolled as members hundreds of graduates of the Woman's Medical College of Pennsylvania, which has indeed "become the world center for women in medicine."

THE PROCTOSCOPE AND THE EARLY DIAGNOSIS OF CANCER OF THE RECTUM

The rectum continues to be the one body orifice which the physician does not adequately examine, although it surpasses both the mouth and the vagina as a site for cancer. It has been shown repeatedly that approximately 50 per cent of all cancers of the large bowel are in the rectum within reach of the examining finger and that these, plus an additional 20 per cent, can easily be seen through the proctoscope. One or both of these procedures are too frequently omitted even in the presence of symptoms such as rectal bleeding, tenesmus, or change in bowel habit, any one of which *should* direct the physician's particular attention to the area, and this failure is alone responsible for many of the deaths from cancer of the colon.

The surgical management of cancer of the colon is based on sound principles and is followed by a far better rate of "cure" than follows the management of cancer of any other part of the gastro-intestinal tract. It has been variously

reported that from 25 to 50 per cent of all patients who have cancer of the lower bowel which is within reach of the finger are treated by suppositories, injections, and even anal operations with a resultant loss of many months in time before the correct diagnosis is made. The resectability rate in such cases is low and the curability rate is even lower. Foss¹ was able to remove the tumor in less than 50 per cent of his cases due to late diagnosis and reported that 2000 deaths occur each year in Pennsylvania from cancer of the colon.

Many cancers of the colon arise from polyps. Their importance as a premalignant lesion is well known, but it is only recently that attention has been called to the fact that they occur in from 7 to 10 per cent of the adult population. They can be missed on digital examination, but are easily seen through the proctoscope. Swinton² states that "if large numbers of these premalignant lesions are to be discovered, not only must every patient with any symptom referable to the large bowel be carefully investigated but sigmoidoscopic examinations must be a routine part of every complete examination. Only when a sigmoidoscope is considered as important a part of one's diagnostic equipment as the stethoscope, vaginal speculum, laryngoscope, and otoscope will large numbers of these tumors be found and an appreciable number of patients saved from the development of cancer."

The importance of the proctoscope and the simplicity of its use have not been sufficiently emphasized. Its routine use in all patients with rectal symptoms would not only reveal many unsuspected polyps but would eliminate many of the errors in diagnosis and treatment which are now common when cancer and hemorrhoids are present in the same patient. The value of the digital rectal examination is not to be minimized, but it is not as reliable as is visual examination through the proctoscope, nor has the oft-repeated emphasis on the importance of its use resulted in any material increase in the number of cancers of the rectum which receive proper treatment at the earliest opportunity. The more widespread use of the proctoscope by the practitioner is one approach to early diagnosis which has not been adequately explored. The instrument is not difficult to use and, when inserted and advanced under direct vision, is without danger in the hands of the man who has been shown how to

use it. The physician who has a proctoscope and knows how to use it is not a proctologist but rather a better physician.

JAMES R. WATSON, M.D.

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VITAMIN ANTAGONISTS—CLINICAL IMPLICATION

(EDITOR'S NOTE: This is the first of a series of guest editorials prepared for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania. With the present-day interest in applied physiology as displayed by clinicians, this series on its nutritional phase should prove timely, interesting, and instructive. Many readers of the appended editorial may find new light in the explanation of the mode of action of certain chemotherapeutic drugs.)

A vitamin antagonist, or antivitamin, is the structural analogue of an essential vitamin and inhibits that vitamin's biologic action and so produces signs of a specific deficiency disease. The signs of the induced deficiency disease can be cleared up by the missing vitamin.

To illustrate: Nicotinic acid, which is necessary to the growth of certain bacteria, results, when slightly modified in structure, in an antagonist, pyridine-3-sulfonic acid (SO_3 for COOH). This antagonist inhibits the growth of the bacteria. Nicotinic acid will counteract the inhibitory effect of the antagonist. Another example of a vitamin antagonist is the analogue of ascorbic acid, gluco-ascorbic acid, so called. This antagonist when fed to animals causes the typical syndrome of scurvy. The administration of ascorbic acid will reverse the pathologic changes of scurvy.

The physiologic action of antivitamins is not definitely known. They may act by uniting with their respective vitamins to form irreversible compounds and so make the vitamins unavailable; or they may competitively interfere with the action of the vitamins. But the phenomenon of biologic competition of structurally related compounds has many practical implications.

From a clinical point of view, for example, it is important because it helps to explain the mode of action of several important chemotherapeutic drugs.

To illustrate: The action of sulfanilamide is not germicidal in the accepted sense, nor does it

stimulate antibody formation. Its action depends on the competitive inhibition of para-aminobenzoic acid (a doubtful member of vitamin B complex) by sulfanilamide. Para-aminobenzoic acid is chemically similar to sulfanilamide. Hemolytic streptococci utilize para-aminobenzoic acid for growth. Sulfanilamide competitively displaces this factor and so interferes with the growth of the streptococci. This results in bacteriostasis.

The biologic competition of structurally related compounds has led to the development of new chemotherapeutic agents.

In recent years many antivitamins have been isolated or synthesized, but only a few of them have been used in clinical medicine. Of these, the folic-acid antagonist, aminopterin, has aroused most interest, for aminopterin will sometimes produce remission in acute leukemia. The use of aminopterin in acute leukemia is based on Farber's observation that folic acid or one of its conjugates intensifies the severity of the leukemic process. It was natural to reason, therefore, that, by blocking the nutritional availability of the folic acid by means of an antagonist, the proliferation of leukemic cells could be inhibited. Indeed, when the folic acid antagonist, aminopterin (4 amino pteroyl-glutamic acid), was employed in the treatment of children with acute leukemia, more than 50 per cent of the children showed definite clinical and hematologic improvement. Though spontaneous remissions occasionally occur in acute leukemia, the incidence of such remissions is much lower than the incidence of remissions after the administration of aminopterin. (In St. Louis Children's Hospital the incidence of spontaneous remissions is reported as less than 1 per cent.) It should be borne in mind that aminopterin is not a cure; it may prolong the patient's life and comfort for some months, but its effects are only temporary. Furthermore, aminopterin may be toxic. The first sign of intoxication may be ulceration of the lips and the buccal mucosa. Sometimes oral hemorrhages ensue.

In the Philadelphia Children's Hospital, aminopterin has proved far superior, however, to blood transfusions, urethane, and all other methods employed in the past for the relief of acute leukemia. It is to be hoped that a better compound than aminopterin may be found for the treatment of leukemia.

It is interesting to note that antagonists to certain amino acids have also been synthesized. For

example, indoleacrylic acid, an antagonist of tryptophane, interferes with the growth of *E. coli*; its inhibitory effect is reversed by tryptophane. And recent experimental work suggests that a synthetically prepared antagonist of thyroxine inhibits the action of the hormone in the peripheral tissues. At present, unfortunately, there is no available thyroxine analogue for clinical use.

But chemotherapy has entered upon a new day, for the concept of the biological antagonism of structurally analogous compounds is being actively explored in many laboratories.

MICHAEL G. WOHL, M.D.,
Chairman, Commission on Nutrition.

KEYSTONES OF PUBLIC HEALTH IN PENNSYLVANIA

Training

(EDITOR'S NOTE: This is the fourth of a series of guest editorials planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.)

This chapter calls attention to the recognized fact that both basic professional and continuous education is vital to the efficient and effective functioning of any staff. It calls attention to the serious weakness of the public health program in Pennsylvania because of lack of trained personnel.

In good public health practice throughout the United States, a very important function and responsibility of a state department of health is to stimulate, guide, promote, and make available training for public health workers in local units as well as on its own staff. This, moreover, is a matter of law and regulations in Pennsylvania.

In order to provide local health services, there will be need for at least 35 competent medical health officers throughout the State within the next few years. Nearly all of these will have to be trained. The larger cities of the State and the State Health Department itself need about 20 additional. Besides these, 55 physicians who will

have to be trained, engineers, sanitarians, and nurses will need the same sort of education. Besides formalized special education, there is need for a short course on-the-job or in-service training for all types of public health workers.

This sort of training should be available to groups outside the Health Department, such as pasteurizing plant operators and industrial hygienists.

Attention is invited to the fact that many of the policy-makers, both in state and local organizations, are part-time administrators. Most of these people are not formally prepared in public health, and their chief interest and attention are in the private practice of medicine or dentistry, or business, or in other fields. Unquestionably, this is partly responsible for the lack of training procedures and at the same time makes the need greater. Part-time administration almost inevitably means day-to-day expediency operation, with a minimum of planning and promotion, and gradually results in a loss of appreciation of the possibilities of achievement by full-time, adequately trained staffs.

The School of Public Health of the University of Pittsburgh holds great promise for relieving a part of the training load. However, three levels of training must be recognized, and while a graduate school of public health will make a significant contribution, it will not solve all the problems. The levels are:

1. Graduate training of physicians, dentists, engineers, nurses, and administrators leading to degrees in public health.
2. "Undergraduate" training in public health of physicians, dentists, and nurses in their professional curricula.
3. Training of sanitarian assistants, inspectors (both state and local), food handlers, dairy workers, and similar groups on a subcollegiate or vocational school basis.

The report recommends that a unit of training be established as a permanent and integral part of the department.

I. HOPE ALEXANDER, M.D., *Director*,
Department of Public Health,
Pittsburgh, Pa.

IT'S YOUR MOVE, DOCTOR!

The English physicians lost their battle against socialized medicine because they were too polite to fight. This inertia proved to be a costly blunder as most of the British physicians now admit. A stiffer fight might have prevented the chaotic conditions now existing and lightened the taxes not only here but also in the British Isles.

State medicine strictly is a political battle. Most physicians are against it, but to date only a handful have done anything about it. A campaign of this nature requires more than all the Whitaker and Baxters in the country; it requires the combined cooperation of us all. The campaign requires the individual efforts of every American physician. The battle will not be won in Washington but by convincing patients and friends at home that state medicine is bad medicine for the country. To do this, every physician must know the facts, pro and con, as well as he knows the symptoms of appendicitis. It is the grass root strategy of campaigning in the local community that "brings home the bacon."

Many physicians think that they are too big to resort to grass root politics; others let it be known that they are so absorbed in the practice of good medicine that they cannot be bothered. We admire everyone who has the welfare of the public at heart, but a new variable has been added to alter the picture. In our opinion, state medicine lowers the standard of medical care and in this respect should stimulate the most conscientious physician to remove his gloves and get in and pitch. Nowadays a physician must be more than a good doctor if he wants to remain a free doctor.

We live in a free country, but actually our fate rests in the hands of 435 congressmen and 96 senators. In other words, if we want the politicians to be interested in our cause, we must be interested in theirs. It has been reported that in one city approximately one hundred physicians were not registered and could not vote if they wanted to. Inertia was also evident in the 1948 campaign. A plea for campaign money was sent by a Republican organization to physicians in a certain county in Illinois. Not one of them responded even though it meant sending a loyal supporter to Congress. What would you think if you were a congressman and were asked to help a cause in which the constituents involved showed absolutely no interest? In the 1950 elections let us remember that it is easier to settle issues at the polls than in Congress at a later date.—*Illinois Medical Journal*, October, 1949.

An interesting article on the survey report "Keystones of Public Health for Pennsylvania" written by George S. Klump, M.D., and presented at both the Fourth Annual Conference of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania and the Annual Conference of Secretaries and Editors is printed on pages 411 to 415 of this issue.

SAYS MEDICAL SCHEME ABROAD IS "ROTTEN"

For some time the AMA has been using a reproduction of the famous Fildes painting, "The Doctor," on its business envelopes, with the admonition "Keep Politics Out of This Picture." One of these envelopes, bearing AMA centennial stamps issued in 1947, came to the attention of an architect surveyor in Leicester, England, through philatelic correspondence with John Mirt of AMA press relations. The Englishman wrote Mirt:

"I think the idea of yours regarding the Fildes reproduction on your envelopes is a great scheme, and I am so pleased to think you are putting up a fight against socialized medicine. We are well in it. The whole scheme is rotten to the core and should be repealed. In this country it is a fearful flop, and to my mind it is degrading to men who are undoubtedly of high intellect and ability."

NEW INDUSTRIAL HEALTH GRADUATE PROGRAM

General Motors has announced that, in cooperation with the University of Michigan, it is inaugurating a new type of postgraduate training program in industrial health techniques for young physicians who have completed their internships.

Under the program, first of its kind to be established in the country, the physicians will be in the employ of General Motors for a period of twelve months. Eight months of this period will be served in the medical departments of General Motors and four months will be spent at the University of Michigan School of Public Health.

During the months spent in the medical departments of GM, these physicians will become familiar with the General Motors medical service programs, working with industrial physicians and technicians who have had many years of practical service in this field. At the School of Public Health in Ann Arbor, they will study basic introductory courses in public health administration, environmental health, epidemiology, and health economics.

This unique program, which compares with the resident hospital training many young physicians now undergo in other fields of medicine and surgery, was conceived and worked out by Dr. Max R. Burnell, medical director of General Motors; Dr. Henry F. Vaughan, dean of the School of Public Health of the University of Michigan; and Dr. C. D. Selby, resident lecturer in industrial health at the University of Michigan.

Any young man who has completed his internship in an approved hospital and is interested in industrial health work may apply for this training program through the General Motors Medical Director, General Motors Bldg., Detroit. Applications will be accepted beginning February 1. Young physicians now serving their internship may begin this program after July 1, 1950.

"THEY STOOD UP AND WERE COUNTED"

Three hundred and seventy-five organizations in the Commonwealth have raised their voices in formal protest against compulsory health insurance. This is the "grass roots" voice of Pennsylvania.

There is still a great untapped source of power in organizations which have not yet gone on record. Pennsylvania's goal in the National Education Campaign is 1000 resolutions from *local* organizations in small as well as large communities. In this field lies a *real* and *potent* influence on national legislation.

More than 5000 local groups—including women's clubs, branches of the American Association of University Women, American Legions and Auxiliaries, Veterans of Foreign Wars and Auxiliaries, local Chambers of Commerce, local Granges and Farm Bureaus—have been contacted by mail through the State Society, requesting them to take a formal stand on this issue. We strongly urge county medical societies and auxiliaries to follow through on these contacts. Where an organization has not responded to our initial contact, please arrange to have a personal friend or influential member of your community talk with the presidents or chairmen of these groups, encouraging them to adopt resolutions against compulsory health insurance.

Perhaps you know of some organization, not listed here, which is on record against political medicine. If so, will you please send the information to the Committee on Public Relations, 230 State Street?

We cannot reach our goal of 1000 resolutions without the help of *every* physician and his wife. Will you help?

On Record Against Compulsory Health Insurance in Pennsylvania

State Organizations (19)

Pennsylvania Society for Crippled Children and Adults, Inc.
Funeral Directors Association of the State of Pennsylvania
The Medical Society of the State of Pennsylvania
Middle Atlantic Hospital Assembly
Pennsylvania Academy of Ophthalmology and Otolaryngology
Pennsylvania Academy of Physical Medicine
Pennsylvania Association of Insurance Agents
Pennsylvania Federation of Women's Clubs
Pennsylvania Fraternal Congress
Pennsylvania Public Health Association
Pennsylvania Society—Daughters of the American Revolution

Pennsylvania State Chamber of Commerce
Pennsylvania State Dental Society
Tax Justice League of Pennsylvania, Inc.
Woman's Auxiliary to The Medical Society of the State of Pennsylvania
Pennsylvania State Veterinary Medical Association
Homeopathic Medical Society of Pennsylvania
Women's Homeopathic League of Pennsylvania
Chiropody Society of Pennsylvania

Service Clubs (20)

Altoona Rotary Club
Bedford County Pomona Grange No. 24
B'Nai B'Rith of Scranton
Cambria County Pomona Grange
Kiwanis Club of Carbondale
Kiwanis Club of Harrisburg
Kiwanis Club of Knoxville (Mt. Oliver)
Knox Community Club
Lions Club of Dalton
Lions Club of DuPont
Lions Club of Harrisburg
Parkers Landing Rotary Club
Somerset County Pomona Grange
Wise Men's Club of Scranton—Y. M. C. A.
Y. M. C. A. Forum (Scranton)
Young Women's Christian Association (Norristown)
Optimist Club of York
Child Welfare Circle (Brookville)
York Traffic Club
Rotary Club of Parker

Chambers of Commerce (21)

Chamber of Commerce of Erie
Hanover Junior Chamber of Commerce, Inc.
Johnstown Junior Chamber of Commerce
Wilkesburg Chamber of Commerce
Reading-Berks Chamber of Commerce
Beaver Falls Board of Trade
Bellefonte Chamber of Commerce
Chambersburg Chamber of Commerce
Easton Area Chamber of Commerce
Harrisburg Chamber of Commerce
Jeannette Chamber of Commerce
Lewisburg Chamber of Commerce
Ligonier Valley Chamber of Commerce
Meyersdale Chamber of Commerce
Mansfield Business Men's Association
Norristown Chamber of Commerce
Pittsburgh North Side Chamber of Commerce
Washington Chamber of Commerce
Schuylkill Haven Chamber of Commerce
Waynesburg Chamber of Commerce
Wyoming Valley Chamber of Commerce (Wilkes-Barre)

Medical Organizations (19)

Auxiliary to the Odontological Society of Western Pennsylvania
Cambria-Somerset Pharmaceutical Society
Council of the Philadelphia Neurological Society
Lackawanna County Pharmaceutical Association
McKeesport Academy of Medicine of Allegheny County
Philadelphia Academy of Surgery
Philadelphia District Dental Hygienists' Association
Philadelphia Proctological Society
Philadelphia Roentgen Ray Society
Section on Clinical Pathology of the Philadelphia County Medical Society
Reading Eye, Ear, Nose and Throat Society
Southeastern Chapter of the Pennsylvania Society of Medical Technologists and Laboratory Technicians
Reading Dental Society
Brookville Hospital Nurses' Association
Lee Hospital Auxiliary (Johnstown)
P.S.E.A. Hospitalization Group (Duquesne)

Woman's Auxiliary to Indiana County Memorial Hospital

Laennec Society of Philadelphia

York County Dental Society

American Legions (4)

Rogers Isreal Post No. 11 (Erie)

Johnstown Post No. 294

Hershey Post No. 386

Sharon Post No. 299

American Legion Auxiliaries (8)

Rogers Isreal Unit No. 11 (Erie)

John M. Anderson Unit No. 424 (Bellwood)

Myerstown Unit No. 55

Bentleyville Unit No. 165

Frankford Unit No. 211

Carlisle Unit No. 101

Nanticoke Unit No. 350

Robert B. Woodbury Unit No. 67 (Pottsville)

Veterans of Foreign Wars (3)

White Rose Post No. 556 (York)

Barclay Robinson Phillips Post (Westland)

Liberty Bell Post No. 1906 (Philadelphia)

Veterans of Foreign Wars Auxiliaries (10)

Post No. 5430 (Shickshinny)

Walter L. Hagelgen Post No. 8353 (West Hazleton)

Francis B. Pritchard Post No. 464 (Oil City)

D. Merle Tifton Post No. 43 (Martinsburg)

Anthracite Auxiliary to Post No. 283 (Kingston)

Drake-Wear Post No. 589 (Hazleton)

Barclay Robinson Phillips (McDonald)

Post No. 373 (Homestead)

Bauer-Hartman-Marsjalek Post No. 9198 (Andalusia)

Hunter-Weaver Post No. 795 (Scalp Level)

American Veterans of World War II (2)

McKeesport Post No. 8

York Post No. 2

Daughters of the American Revolution (21)

Penn-Elk Chapter (Ridgway)

Colonel William Wallace Chapter N.S. (Pittsburgh)

Valley Forge Chapter (Norristown)

Gettysburg Chapter

Bradford Chapter (Canton)

Perry County Chapter (Duncannon)

Philadelphia Chapter (Bryn Mawr)

Phoebe Bayard Chapter (Greensburg)

Braddock Trail Chapter N.S. (Mt. Pleasant)

Du Bois Chapter (Du Bois)

Girard Chapter (Girard)

Philip Freeman Chapter (Connellsville)

Wyoming Valley Chapter (Dallas)

Dial Rock Chapter (West Pittston)

Great Meadows Chapter (Uniontown)

Triangle Chapter (North East)

Tunkhannock Chapter (Tunkhannock)

Chester County Chapter (Downingtown)

Sally Wister Chapter (Bradford)

Susquehanna Chapter (Clearfield)

Shikelloni Chapter (Lewisburg)

Parent-Teacher Associations (3)

P.T.A.—John Adams School (Scranton)

P.T.A.—York City

P.T.A.—Osceola Mills

Women's Christian Temperance Unions (3)

Reading-Berks County—Anna Gordon W.C.T.U.

Reading-Berks County—Lillian Stevens W.C.T.U.

Ferndale W.C.T.U. (Johnstown)

Business and Professional Women's Clubs (5)

York Business and Professional Women's Club

Kennett Square Business and Professional Women's Club

Mars Business and Professional Women's Club

Northampton Business and Professional Women's Club

Wilkes-Barre Business and Professional Women's Club

Insurance Organizations (2)

Women's Insurance Society of Philadelphia

Hanover-Gettysburg Association of Life Underwriters

County Medical Societies (50)

Adams

Allegheny

Armstrong

Beaver

Berks

Blair

Bradford

Bucks

Cambria

Carbon

Chester

Clearfield

Clinton

Columbia

Crawford

Cumberland

Dauphin

Delaware

Elk

Erie

Fayette

Franklin

Greene

Indiana

Jefferson

Lackawanna

Lancaster

Lawrence

Lebanon

Lehigh

Luzerne

Lycoming

McKean

Mercer

Monroe

Montgomery

Montgomery (Main Line Branch)

Montour

Northampton

Northumberland

Perry

Philadelphia

Schuylkill

Susquehanna

Warren

Washington

Wayne-Pike

Westmoreland

Wyoming

York

County Medical Society Auxiliaries (32)

Armstrong

Beaver

Berks

Blair

Bucks

Butler

Cambria

Carbon

Centre

Clearfield

Clinton

Cumberland

Elk-Cameron

Erie

Greene

Indiana

Lancaster

Lehigh

Luzerne

Luzerne (Hazleton Branch)

Mercer

Montour

Northampton

Perry

Philadelphia

Schuylkill

Somerset

Susquehanna

Washington

Wayne-Pike

Westmoreland

York

Women's Clubs (128)

East Liberty Woman's Club

The Lookout Club (Emporium)

The Neighbors (Hatboro)

Westmoreland County Federation of Women's Clubs

Coraopolis Junior Woman's Club

Woman's Club of Monongahela

Women's Civic Club (Mifflintown)

Woman's Club of Leechburg

Junior Women's Club (Media)

Midland Civic Club Juniors

Warrington Woman's Club

Women's Civic Club (Plymouth)

Junior Women's Civic Club (Indiana)

The Fleetwood Woman's Club

Civic Club of Harrisburg

The Woman's Club of Catasauqua

The Woman's Civic Club (Blairsville)

Junior Department of the Woman's Club of Oakmont

Prospect 20th Century Club

Junior Woman's Club (Baden)

Old York Road Contemporary Club (Jenkintown)
 Ulysses Woman's Club
 Junior Woman's Club (Butler)
 Ambridge Junior Woman's Club
 Mary Ferree Society (Paradise)
 Leeper Women's Club
 Montrose Monday Evening Club
 Warrington Junior Women's Club
 Woman's Club (Reading)
 Federated Monaca Junior Woman's Club
 Telford Junior Woman's Club
 Woman's Club of Sewickley Valley
 Woman's Club of Frackville
 The Outlook Club (Beaver Falls)
 Sharpsville Woman's Club
 Yardley Junior Civic Club
 Columbian Literary Society (Mansfield)
 Woman's Club of Beaver
 Junior Women's Club of Sharon Hill
 Renovo Monday Night Club
 Women's Research Club of Oxford
 Irwin Woman's Club
 Woman's Literary Club of Sandy Lake
 Community Club of New Albany
 Renovo Civic Club
 Junior Woman's Club (Monessen)
 West Bridgewater Woman's Club
 Woman's Club of Kutztown
 Lititz Woman's Club
 Marple Township Woman's Club (Broomall)
 Woman's Club of Stonehurst
 Altoona Senior Woman's Club
 Myerstown Woman's Club
 Woman's Club of Aliquippa
 Fine Arts Club (Monongahela)
 The Woman's Club (Clearfield)
 New Century Club of Indiana
 Community Club (Harmony)
 The Philomusian Club (Philadelphia)
 Knox Civic Club
 Woman's Club of Curwensville
 Donora Woman's Club
 Montrose Junior Women's Club
 The Woman's Club of Drexel Hill
 Grove City Woman's Club
 Charlene Club of Charleroi
 Dallas Woman's Club
 Woman's Club of Monaca
 Sewickley Century Club
 Pine Grove Women's Club
 Village Improvement Association (Canton)
 Review Club of Oak Lane
 The Woman's Club of the Allegheny Valley (Tarentum)
 New Century Club (Beaver Falls)
 Chalfant House Evening Club (Etna)
 Hanover Township Women's Civic Club
 Berks County Federation of Women's Clubs
 Electric Delphian Club (Scranton)
 Woman's Club of Crafton
 Kennett New Century Club (Kennett Square)
 Senior Woman's Club (Ellwood City)
 Evans City Senior Women's Club
 The Women of the Round Table (Du Bois)
 Beaver Junior Woman's Club
 Junior Women's Club—Community Club of Narberth
 Sykesville Woman's Club
 The Woman's Club of Downingtown
 Woman's Club of Birdsboro
 Carbondale Delphic Club
 The Century Club (Coatesville)
 McComellsburg Woman's Club
 The Woman's Club of Franklin
 Junior Women's Club of Evans City

Woman's Club of the City of Pittsburgh
 Woman's Club of Swissvale
 Junior Woman's Club (Pottsville)
 The Parliamentary Law Club (Scranton)
 Mother's Study Club (Connellsville)
 Mars Literary Club
 Bucks County Federation of Women's Clubs
 The Senior Women's Club (Philipsburg)
 Monessen Woman's Club
 Wednesday Club of Towanda
 Summit Hill Woman's Club
 The Travel Club of Bristol
 Morrisville Woman's Club
 Zelienople Junior Community Club
 Woman's Club of Ardmore
 Women's Club of Duquesne
 Junior Women's Club (North East)
 The Iris Club of Sunbury
 Woman's Club of Slatington
 Overbrook Woman's Club
 Townville Woman's Club
 Luzerne County Federation of Women's Clubs
 Harvey's Lake Women's Service Club
 Junior Saturday Club of Wayne
 Woman's Club of Columbia
 Woman's Club of York
 Junior Woman's Club (Lebanon)
 Woman's Club of Oley
 The Woman's Club of West Pittston
 The Woman's Club (Stroudsburg)
 Junior Women's Club of West Pittston
 Plymouth Junior Women's Civic Club
 Civic Club of New Milford
 Woman's Club of Factoryville
 Philadelphia Federation of Women's Clubs & Allied Organizations, Inc.

Miscellaneous (25)

Continental Congress Chapter—Sons of the American Revolution (York)
 Johnstown Chapter of the National Secretaries' Association
 Women's Society of World Service of the Homestead Avenue Evangelical United Brethren Church (Johnstown)
 York Real Estate Board
 Allegheny County Funeral Directors Association
 The Valley Branch—National Metal Trades Association
 Waynesboro Manufacturers' Association
 Welfare Agency of Dunmore
 Young Adult Group, Westminster Church (Scranton)
 Young Adult Group, Myrtle Street Methodist Church (Scranton)
 Fidelis Bible Class, Evangelical United Brethren Church (Homestead)
 Pennsylvania Society of Professional Engineers (Philadelphia Chapter)
 7th Ward—Women's Republican Club (Johnstown)
 Capital City Sisterhood No. 53, Dames of Malta (Harrisburg)
 Ladies Independent Order of Reindeer (Easton)
 Abington Woman's Republican Club
 Federation of Women's Republican Club (Scranton)
 1938 Green Ridge Woman's Republican Club (Scranton)
 1923 Woman's Republican Club (Scranton)
 Young Woman's Republican Club (Scranton)
 Martha V. Conrad Study Club (Brookville)
 Gamma Alpha Chapter—Beta Sigma Phi Sorority (York)
 Upper Darby Council of Republican Women
 Women's Prospect Republican Club (Johnstown)
 Junior Service League of York, Inc.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

1950 COUNCILOR DISTRICT MEETINGS

First District—March 29 at Philadelphia
Second District—May 10 at Reading
Third and Fourth Districts combined—April 13
at Bethlehem
Fifth District—May 18 at York
Sixth District—May 18 at State College
Seventh District—May 3 at Williamsport
Eighth District—June 14 at Union City
Ninth District—June 15 at Punxsutawney
Tenth District—June 8 at Pittsburgh
Eleventh District—June 8 at Washington
Twelfth District—June 21 at Dallas

AMA DUES NECESSARY BECAUSE—

The appended communication from the American Medical Association was received during the month of March by the membership of The Medical Society of the State of Pennsylvania. It very briefly sets forth accomplishments of the AMA which have benefited the people of the United States not only through the members of the medical profession but less directly through many civic, state, and national sources of information and service. Some evidences have been received in the office of the State Society's secretary-treasurer of annoyance to members who had paid their 1950 county and state society and AMA dues in full before they received the appended letter.

This communication affords a good opportunity for us to again remind all Pennsylvania doctors who were members in good standing on Dec. 31, 1949, that they will be considered by the AMA throughout the year 1950 as members on the basis of such membership held automatically in 1949 through county and state society membership. Members who do not pay their 1950

AMA dues will, at the end of 1950, be notified by the AMA that they are being dropped from membership for failure to pay 1950 dues. We again suggest to such members the wisdom of paying such dues or writing a letter of resignation to the American Medical Association, 535 N. Dearborn St., Chicago 10, Ill., in order that their long career as members may not soon be marred by delinquency.

DEAR DOCTOR:

Membership in the American Medical Association so long has been automatic without financial obligation that it has been taken for granted. It is not realized that the entire framework of medicine in the United States today is due primarily to the activities of the American Medical Association.

Consider the following:

Medical education was at a low ebb less than fifty years ago. It was the intensive campaign of the American Medical Association that did most to raise medical education to its present high level. Roundly excoriated for attempting this in the beginning, now it is praised for having done so. The high standards of our hospitals, too, were achieved in large part by the activities of the American Medical Association, especially the hospital inspection and approval program of the Council on Medical Education and Hospitals.

The establishment of the Council on Pharmacy and Chemistry aroused, originally, great opposition, but now it is recognized that the rules for acceptance set up by that Council have protected the public and given the doctor confidence in the purity and efficiency of any American Medical Association approved product. The later establishment of the Association's Council on Foods and Nutrition and Council on Physical Medicine and Rehabilitation likewise has given both the public and the doctor assurance of good scientific information and has given the doctor a means of assessing the value of therapeutic appliances.

The Library of the American Medical Association is open to any member. He may obtain a package library on any subject to improve his knowledge or help him write a paper. The Quarterly Cumulative Index Medicus lists the important medical literature of the world and has been published for the profession by the Association at a great financial loss.

The Bureau of Investigation has kept American Medical Association members and the public informed

about nostrums and quackery and, with the assistance of the Food and Drug Administration and the Federal Trade Commission, has been able to stop many frauds from being perpetrated on the public.

Two scientific sessions of the national association are held each year. They are now and have been for the past year open to members as well as to Fellows. They are in themselves a postgraduate course of instruction. Nowhere else in the world can such an array of scientific exhibits be seen or scientific papers be heard.

The Council on Medical Service has been responsible for the study and promotion of voluntary health insurance, which has made it easier for many people to pay their medical bills.

The Council on National Emergency Medical Service has stimulated the establishment of civilian medical advisory committees at the highest policy level of the government, which have already achieved significant advances in the economic utilization of medical officers in peacetime and in any future war emergency.

The Handbook of the American Medical Association, which is being sent to you under separate cover, outlines more fully the splendid contributions that are being made by the various councils, committees, and bureaus to the welfare of the individual physician and his county and state medical societies and to the general health and well-being of the American people. Included are outlines of activities of many other councils, bureaus, and departments that I have not mentioned in this letter.

For the past ten years, the American Medical Association has battled for freedom in medicine. Its efforts have prevented the socialization of medicine and the enslavement and regimentation of the medical profession. The fact that you are still practicing under a free enterprise system is due, principally, to the efforts of your Association. Does not a member, therefore, owe something to his Association? If he fails to pay his dues, not only will he lose membership in the American Medical Association but he will, in effect, be voting for the socialization of medicine by not supporting the organization which has protected him against it.

The general income of the Association is not sufficient to cover all the expanded scientific activities of the Association, and dues would be necessary in any event, even if there were no National Education Campaign. It is expected that this coming year will see a still more positive approach to the development of voluntary health insurance as the major part of the campaign.

In any event, will you not pay your national dues promptly to your state or local society, as designated by your own state society, and give your Association this evidence of your support of its many activities and services, heretofore rendered gratis, which have been so closely interwoven with your entire professional life and have contributed so much to the general welfare?

Sincerely yours,

LOUIS H. BAUER, M.D.,
Chairman, Board of Trustees,
American Medical Association.

March 7, 1950

SURVEY OF PHYSICIANS' INCOMES

Do Your Profession a Service

Late in April the Bureau of Medical Economic Research of the American Medical Association and the Office of Business Economics of the U. S. Department of Commerce will jointly conduct a survey of physicians' incomes.

The Bureau has been authorized by the AMA Board of Trustees to cooperate in this survey, which the Department of Commerce had planned to conduct alone. It will be the first full-scale survey by the department of physicians' incomes since 1941.

An analysis of the results will be published by the Department of Commerce next fall in its monthly publication, "Survey of Current Business." Its August, 1949 and January, 1950 issues had published similar analyses of surveys of incomes of dentists and lawyers, respectively, made jointly with the American Dental Association and the American Bar Association.

There is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill out questionnaires do not reply in sufficient numbers. Accordingly, the Bureau emphasizes the importance of all doctors, especially those with a relatively small practice, filling out the questionnaires.

Accurate postwar data on physicians' incomes are badly needed in order to develop better estimates of how much the American people pay to physicians.

Every physician can be assured that the survey has no relation whatever to the operations of the U. S. Bureau of Internal Revenue. There is no way by which the Department of Commerce could have obtained the needed information from the Bureau of Internal Revenue; hence, the questionnaire survey.

There will be two questionnaire forms. The Bureau of Medical Economic Research helped to design these. A short form will request income data for 1949 only. A long form questionnaire will cover the years 1945 through 1949. *All are to be returned unsigned in franked envelopes.*

The punch card files of the Bureau of Medical Economic Research contain the names of about 200,000 physicians. The survey will cover 125,000 of these, or 62½ per cent of the total. Selection will be by a formula which eliminates any partiality.

A short form will be sent once only to *every other* name in the file. Of the remaining 100,000 names, every fourth will be selected. To these will go 10,000 short forms and 15,000 long forms, with this distinction—the return franked envelopes will carry a code number which will identify the physician to the Bureau of Medical Economics Research alone. All of the addressing will be done in the headquarters of the AMA.

The sole purpose of the code number is to enable the AMA Bureau of Medical Economic Research to address a follow-up letter to those not replying to the first request. *Physicians need have no suspicion about the code number because when the reply is received, the questionnaire will be separated immediately from the envelope and the identity will be lost.*

Physicians will be doing the medical profession a service by filling out the forms and returning them as soon as possible.

PENDING FEDERAL HEALTH LEGISLATION AND OTHER ACTIVITIES OF THE COMMITTEE ON PUBLIC HEALTH LEGISLATION

This statement will be divided into four parts: (1) consideration of the important bills in the Federal Congress, (2) general conditions, (3) activities of the committee, and (4) items to be discussed with legislators and Congressmen concerning compulsory health insurance.

Following are a few of the important bills under consideration in the Federal Congress as of March 1:

All compulsory health insurance bills, including the more recent ones with deductible features, have been disapproved by the AMA Coordinating Committee on Legislation and are resting in the Subcommittee on Health of the House Interstate and Foreign Commerce Committee. The chairman of the committee has stated that he expects to have hearings on these bills the latter part of May or in June.

Senate Bill 1453 provides aid for medical education and is also in the Subcommittee on Health. Amendments are being considered.

The National Science Foundation bill which passed the House is somewhat different from the

Senate bill. It will go to a conference committee for consideration and agreement.

Another bill providing Federal grants-in-aid to the states for medical care and treatment for school children in the public schools of the United States is still in the House Committee. Amendments adopted give recognition to the family physician. It is the hope of the AMA Coordinating Committee that Section C of this bill can be eliminated. This section provides for treatment of all school children irrespective of financial eligibility.

The bill providing for Federal subsidy for public health units is still under advisement in the House Committee.

At present, due to recent planned taxation, wealth is more generally distributed. There remain very few philanthropic funds available for health and medical research work. As a result of this economic condition, individuals and groups of individuals go to the Federal Congress asking for aid through various tax funds. When such tax funds are granted, Federal control necessarily follows.

The medical profession is endeavoring to retain the individual and direct responsibility of the physician to his patient under these difficult conditions.

These are the times that try one's soul.
The summer soldier and the sunshine patriot
shrink from duty,
But each of us must have the courage to carry
on.

We must formulate a system whereby procedures can be carried out.

We must obtain the services of individual doctors and members of the Woman's Auxiliary in each legislative district. Their duty will be to urge other doctors and their families in the legislative districts to register and to vote. They shall also inform the legislative and congressional candidates as to our viewpoint on pending health and service bills.

There are twenty-five counties in Pennsylvania in which there is more than one legislative district, and forty-two counties with a single legislative district. We wrote the officials in counties having more than one legislative district requesting the boundaries of each district and the number of registered doctors and registered voters in each district. We have heard from eighteen counties to date.

In counties consisting of only one legislative district, the Committee on Public Health Legislation should be supplemented by other doctors in various areas in the entire county to assist the committee.

What shall the individual doctor or auxiliary member say to the candidates or to legislators and Federal Congressmen?

1. Many of them will tell you that the AMA should sponsor a bill in the Federal Congress providing for some form of sickness insurance. This would be difficult for the medical profession to do. If we sponsor a bill, it might be amended to such an extent that it would not be recognized by the time it was passed. If not amended at the session of Congress in which it is introduced, it may be amended several sessions later. If we then remonstrate, those interested will tell us that it was our bill and that we should find no fault with it. The medical profession should not be placed upon a white horse to help lead the parade for Federal legislation which leads us down the road to totalitarianism.

We must depend upon the wisdom of our constitutional lawyers and statements in the Federal Congress to prevent such a catastrophe.

2. You may tell your Federal Congressman that, if he desires to do something basically constructive, he should propose a Federal Department of Health and transfer all Federal medical and health activities to this department which should be headed by a doctor of medicine and properly staffed. The development of a greatly needed concentrated and efficient Federal Department of Health will result in several years of invaluable experience for the ultimate correct solution of the nation's health and sickness problems.

3. Dispel from the minds of our legislators and Congressmen any belief that a compulsory health and sickness service plan is necessary.

Point to our ever decreasing general mortality rates as well as infant and maternal mortality rates resulting from constantly improving medical service and preventive medicine. Together they result in the saving of 1,200,000 lives each year. The 3 per cent pay roll tax would be reflected in the price of commodities you buy. Twenty-seven per cent of the people's money now goes into taxes. The cost of compulsory sickness insurance will add another 5 to 9 per cent. It will create a large bureaucratic organ-

ization in Washington to further administer the affairs of our population with its widely diversified ideas and ideals.

We, as a people, must decide whether we want economy and liberty or profusion and servitude. The people must prevent the government from wasting the labors of man on the pretense of caring for and keeping him always happy.

PROGRESS REPORT OF THE SPECIAL COMMITTEE TO STUDY A GRIEVANCE COMMITTEE

To the Board of Trustees:

The committee met in Harrisburg, Pa., Feb. 25 and 26, 1950, and begs to report as follows:

Need for a Grievance Committee

It is generally conceded that one serious source of public dissatisfaction is the apparent impression that the public does not receive satisfactory and equitable hearings of their complaints under our present judicial procedures. We suspect that much of this dissatisfaction arises from the fact that component county boards of censors are not sufficiently active in discharging their duties. The Constitution and By-laws of the State Society and of most county medical societies clearly defines certain methods of procedure, and at least implies other methods which if conscientiously carried out could completely overcome this dissatisfaction.

Past experience with irregularities in the Veterans Administration Home-Town Care Program, Dr. Palmer's recent urgent letter concerning alleged violations in the medical care program in the Department of Public Assistance, as well as other irregularities brought to the attention of this committee, all point to the necessity of either actually putting our present system of controls to work or finding new methods that will work.

Experience with a Grievance Committee

Experience to date with this form of a state-wide Grievance Committee seems to be confined to one small state with a population and a medical population only 10 per cent of that of Pennsylvania. Colorado's two years' experience seems most happy. Similar programs in a few other states are too immature for evaluation.

Problem of Organization

Based on Colorado's two years' experience of 137 complaints, we in Pennsylvania could anticipate approximately 700 in a similar period. Adequate investigation and disposition of such a volume of complaints would suggest the necessity of a large committee or of regional committees willing and able to donate large blocks of time and energy to this problem. It might be difficult to secure sufficient men willing and able to make such a sacrifice.

Effect of Such a State Committee on the County Society

The establishment of such a committee at the state level would further undermine the autonomy of the county society. Shall power and control come from the grass roots or be imposed upon them?

Suggestions

Pending further experience and study, we believe that the county medical societies should be urged to activate, within their present structures, their Committees on Public Relations and/or their Boards of Censors in the handling of individual complaints from the public, either major or minor.

Whatever form this "activation" in the county medical society may take, it should be brought to the attention of the public.

In our studies thus far, it seemed to us that at the present time the public has no clear-cut right of appeal from the action and decision of a county Board of Censors. The involved doctor can appeal through this Board of Trustees to the district censors of each councilor district for review or redress. The public has no such right of appeal. It would seem, therefore, more equitable if machinery could be set in motion to give the public this equal privilege. We would suggest to this Board that this right of appeal could be clearly given to the public by the insertion of the words "or by the public" in line 14, Section 3, Chapter IV, of the By-laws of this Society.

We recommend that the Board continue this committee for further study of this question, and that this committee be given permission to disseminate to the county medical societies factual information and reports of the experience of this and other states in the handling of this problem.

Respectfully submitted,

JAMES Z. APPEL, M.D.,
HOWARD K. PETRY, M.D.,
WALTER F. DONALDSON, M.D.,
LOUIS W. JONES, M.D., *Chairman.*

DUTIES OF STATE NURSES DISCUSSED

PENNSYLVANIA DEPARTMENT OF HEALTH,
Harrisburg, Pa.

DEAR MISS O'HALLORAN:

At the last meeting of the Wayne-Pike County Medical Society, a discussion came up as to the duties of the state nurses, and I was appointed chairman of a committee to look into this matter, and to report on it at our next meeting, March 16.

Our specific question is in regard to nursing service to patients who are not indigent or emergency cases. In this area, state nurses, in uniform, in state cars, and during working hours, are giving home care to people who are able to pay.

The feeling among the doctors was that the nurses

are wonderful to all patients and answer willingly all requests made of them, but they also felt that patients who are able to pay are not entitled to this free service (that is, baths, enemas, and hypodermic and intramuscular injections such as vitamin B, estrogens, penicillin, and protamine insulin) in their homes.

We realize that the state nurses are here to serve the public, and they must be helpful and courteous, but is there no limit as to their field of duty? Could they not refuse service to patients who they know are able to pay?

A statement from you as to just what their orders from the Department of Health are would no doubt clarify the situation here and mollify the attitude of the doctors toward this problem.

Believe me, Miss O'Halloran, we do have the greatest admiration for your department, and all of us personally admire the nurses here, but it does seem that they are being imposed on, and to the detriment of the private practice of doctors and nurses.

With all good wishes to you in your work and congratulations to you personally on your very fine achievement in Pennsylvania, I am,

Sincerely yours,

NELLIE C. HEISLEY, M.D., Honesdale, Pa.,
Chairman, Committee on Scope of
Duties of State Nurses,
Wayne-Pike County Medical Society.

DR. NELLIE C. HEISLEY,
219 11th St.,
Honesdale, Pa.

DEAR DR. HEISLEY:

I deeply appreciate receiving your letter and having the opportunity to advise you of the state nurses' duties.

First, regarding nursing assistance to patients who are not classified as indigent—upon request of the attending physician, the nurse may render nursing assistance. However, this more or less relates to certain emergencies and special reasons the physician may have for his request. The nurses do not assume this responsibility of their own accord.

Second, certain requests may be made to nurses because we are paid by tax funds. However, when the nurse is in doubt as to eligibility of the request, she appeals to the county medical director and is guided entirely by his advice. It is rather difficult for the nurse to assume this responsibility of refusal. Again she appeals to the county medical director for advice.

We aim throughout our entire program to refer patients to their physician. Believe me when I tell you that many physicians are so busy and yet are so extremely anxious concerning their patients that they may have very definite reasons for asking nursing service.

I have faith enough in the nurses and in Wayne-Pike Counties, as well as faith enough in you, to realize and to know that we do not want in any way to take from the practitioner.

I will confer with Dr. Owens and Dr. Emerson, and

I am sure that the situation can be clarified to the satisfaction of all.

Sincerely yours,

ALICE M. O'HALLORAN, R.N., LL.D.,
Director, Bureau of Public Health Nursing,
Commonwealth of Pennsylvania.

P.S. While you have not asked the question, I would like to advise that the state nurses are on monthly salary. Therefore, they do not accept any fee for home visits.

If I have not answered you to your satisfaction, will you be good enough to let me know and I will endeavor to clarify.

A. M. O'H.

March 8, 1950

VITAMIN E FAVORITE OF LAY PRESS

More than three years ago stories appeared concerning a remarkable new treatment for patients with circulatory disease. The treatment was said to have been discovered by some investigators in London, Canada. It was alleged that large doses of vitamin E, or alpha tocopherol, could effect remarkable recoveries in patients with a wide variety of cardiovascular disorders who had not been benefited by more orthodox therapy. . . .

The first announcement of the possible effectiveness of alpha tocopherol acetate in coronary heart disease appeared as a letter, signed by A. Vogelsang and E. V. Shute, in *Nature*. Subsequently a series of articles appeared in the *Medical Record* setting forth the findings of the London, Ontario, investigators. This work did not contain satisfactory data or controls. In many instances the diagnosis was in doubt, other recognized forms of therapy were used concomitantly, and control cases were not reported. In a panel discussion on cardiac therapy at the June, 1947 meeting of the American Medical Association, the following statement was made: "Vitamin E is of no value in coronary heart disease, hypertension, or rheumatic heart disease."

The Shutes and their co-workers have also reported that varicose ulcers, thrombophlebitis, early gangrene of the extremities, thromboangiitis obliterans, and cerebral thrombosis respond to vitamin E therapy. The disease most recently reported by Vogelsang of the Shute Institute to respond to vitamin E therapy is diabetes.

Guest investigated the effects of vitamin E in juvenile diabetes on 13 patients and did not find any beneficial effects. It should be noted that many of Vogelsang's patients were elderly, since recent investigations at Montefiore Hospital in New York have shown that elderly diabetics have a decreased insulin requirement and some may be controlled by diet alone. Juvenile diabetes, notorious for its severity and the difficulty with which it is controlled, provides a much more rigorous test for any therapeutic agent. . . .

More recently, Bensley and his co-workers carried out a controlled study in which 35 patients with diabetes

were given vitamin E therapy and the results compared with those seen in a comparable group of 20 diabetic patients to whom a placebo was administered.

The authors conclude that evidence was lacking to support the view that vitamin E is of value in the treatment of diabetes mellitus.

The Shute Foundation

"The Shute Foundation for Medical Research," which includes a public relations office, was organized by the Doctors Shute under Ontario Letters patent in 1947. The Foundation is reported to be supported entirely by voluntary public subscriptions and patients' fees.

Recently a booklet entitled "The Shute Research Program" was issued by the Foundation. This booklet contains such frightening headings as "Destroyer of man in his prime CORONARY HEART DISEASE," "The Neglected Scourge of Childhood RHEUMATIC HEART DISEASE" and "The menace of the middle-aged HIGH BLOOD PRESSURE" and purports to set forth the research program of the Institute. Besides the conditions just mentioned, the program includes vascular disease, nephritis, purpura and polycythemia, peptic ulceration, and brain and mental processes. In a section entitled "other research new and continued VASCULAR DISEASE" the following statement is made: "Every time a clot in a leg vessel dissolves after the use of vitamin E this question demands an answer: 'If vitamin E will do that for a leg artery, why not for a coronary vessel?' There is only one answer: 'It will!'"

The lay press already has devoted considerable space to the claimed virtues of vitamin E. The many inquiries arriving at the headquarters office of the American Medical Association indicate that this has had some effect. It is regrettable that the hopes of sufferers from heart disease and other cardiovascular conditions, as well as those of countless diabetic persons, should be falsely raised by unbridled enthusiasm. Those who have truly scientific contributions usually are content to report their findings to critical scientific audiences and to hope for searching analysis by such audiences. Persons who place publicity before facts are doing a disservice to humanity.—Report of AMA Council on Pharmacy and Chemistry in *J. A. M. A.*, Feb. 18, 1950.

THE THOUSANDTH MEETING

The Erie County Medical Society celebrated one hundred years of continuous active existence by holding its thousandth meeting in the form of a Centennial Celebration Dinner on Jan. 21, 1950. The scene of the gala affair was the ballroom of the Lawrence Hotel. The attendance consisted of five hundred members and their guests; the number was stipulated by the limitation of the facilities of the hotel rather than by the enthusiasm of the members of the society.

Dr. John F. Hartman, president of the society, was in the chair and Dr. James D. Stark acted as toastmaster. Dr. Stark's skilled introduction of many notables among our guests was a feature of the meeting.

Members of the clergy, the judges, labor leaders, industrialists, and prominent business and professional men were introduced.

The address of the evening was given by Mr. Jennings Randolph of Washington, D. C.

Much credit for a remarkably successful evening goes to Dr. Benjamin Goldman, chairman of the program committee. Dr. Goldman passes credit on to his assistants.—*The Stethoscope*.

PENNSYLVANIA HEALTH COUNCIL

Minutes of February 11 Meeting

A meeting for permanent organization of the Pennsylvania Health Council was called to order at 2 p.m. in the Old Caucus Room of the Capitol Building in Harrisburg on Saturday, Feb. 11, 1950.

The meeting was called to order by the acting chairman, Gilson Colby Engel, M.D.

The minutes of the meeting of Sept. 20, 1949, were approved as mailed to the membership.

The report of the Organization Committee was then made by Dr. Engel, who reported on the by-laws. Each article of the by-laws was passed on separately after certain amendments had been made. It was moved by Mr. Reimer, seconded by Dr. Crabtree, and unanimously passed by all present that these by-laws be adopted as the official by-laws of the Pennsylvania Health Council.

The Organization Committee also recommended that the Pennsylvania Health Council be incorporated under the laws of the Commonwealth of Pennsylvania.

It was moved by Mr. Frazier, seconded, and unanimously passed that the organizations listed above, including the State Department of Welfare, with Dr. Hilding A. Bengs as representative, be notified of their election as charter members of the Pennsylvania Health Council; that they be asked to accept membership on that basis and appoint each a delegate and an alternate as provided for in the adopted by-laws.

The chairman of the Nominating Committee, Mr. Arthur M. Dewees, then reported for that committee. Nominations were made for the officers and the Executive Committee as follows:

Gilson Colby Engel, M.D., Philadelphia, president
C. Howard Witmer, M.D., Lancaster, first vice-president

Mrs. Philip S. Broughton, Pittsburgh, second vice-president

William G. Mather, Ph.D., State College, secretary
Edward M. Green, Harrisburg, treasurer

Members at large of the Executive Committee

Mrs. J. Stewart Williams, Wilkes-Barre

Ruth W. Hubbard, R.N., Philadelphia

Charles H. Frazier, Philadelphia

Mrs. A. J. Nicely, Erie

Beatty H. Dimitt, Indiana

In view of the fact that only one person had been nominated for each position, and since the by-laws called for two nominees, there was a motion from the floor, which was duly seconded and unanimously passed, that the rules be waived in this instance to proceed with the election. It was moved, seconded, and unanimously passed that the acting secretary, Mr. Charles H. Frazier, Jr., be asked to cast one ballot favoring the election of the nominees.

After announcement of the result of the election of officers, President Gilson Colby Engel of Philadelphia took the chair and Professor William G. Mather assumed the role of secretary.

Dr. C. L. Palmer reported for the Committee on Projects. The recommendations and actions follow:

1. A committee should be appointed to study the Survey Report of the American Public Health Association on the Pennsylvania Department of Health, emphasizing as priority projects:

- a. The study and recommendation of legislation regarding a system to provide security in their positions for individuals employed in the Department of Health.
- b. The formation of local public health units.

It is felt that other recommendations of the survey should be considered a long-range program.

In the meantime, according to recommendations of the Survey, it is necessary to urge decentralization of the State Department of Health.

The committee suggested that the organizations represented on the Pennsylvania Health Council be asked if there has been any activity in their organizations in developing or emphasizing priority of any items on this report.

It was recommended that members of each group be trained to speak on the survey before various organizations.

It was moved by Mr. Frazier that the first project of the Council be such a study of the "Keystones of Public Health" and that a committee be appointed if desired to follow up the matter. Carried.

2. It was moved that each organization in the Pennsylvania Health Council be canvassed to determine what particular health activities it conducts in the various areas of the State, the secretary of the Council to do this. Carried.

3. It was recommended and moved that the complaints which have been received regarding "smog conditions" be referred to the Industrial Hygiene Division of the Department of Health and to the Legislative Committee which has been set up for investigating that matter. Carried.

4. It was moved that the Program Committee of the Council supersede the Projects Committee and carry on its work in suggesting suitable items for study and action by the Council. Carried.

A motion was then made to adopt the entire report. Carried.

Chairman Engel made a few remarks in which he stated that he would appoint the committees required

by the by-laws at a later date. He asked also for permission to arrange for stationery, etc., with Executive Committee approval. This was granted by common consent. He asked the opinion of the group regarding a large spring meeting in Harrisburg with the American Public Health Association's study as the focus of attention. One suggestion was that it be held in the autumn rather than in the spring. The matter was left to the discretion of Chairman Engel and the Executive Committee.

It was moved by Mr. Frazier that annual dues for the first year (1950) be set at \$25 for each organization, without prejudice to any future action by the Finance Committee on the matter. Carried.

It was moved by Mr. Bouterse that the Executive Committee immediately apply for tax exemption and exemption for gifts to the Department of Internal Revenue. Carried.

It was moved by Mr. Frazier that the officers and Executive Committee incorporate at once under the Pennsylvania laws as a non-profit corporation. Carried.

Dr. C. L. Palmer announced that it would be possible to arrange for this incorporation through the legal services of the Committee on Rural Medical Service of The Medical Society of the State of Pennsylvania.

It was agreed that mailings to the membership would continue to be sent out from the office of Dr. Palmer as has been done during the period of organization for the sake of convenience and economy.

Chairman Engel discussed a possible future office in Harrisburg with an executive director employed full time together with an office secretary and mimeographing equipment. He suggested a possible budget of \$20,000 a year in this connection. He suggested also the very good possibility that funds for the establishment and carrying on of such an office might come from various foundations and other organizations interested in health. It was moved to adjourn at 3:40 p.m. Carried.

Respectfully submitted,

GILSON COLBY ENGEL, M.D., *Chairman*
WILLIAM B. MATHER, Ph.D., *Secretary*

CHARTER MEMBERS OF PENNSYLVANIA HEALTH COUNCIL

- *State Department of Agriculture
- *State Department of Health
- *State Department of Public Assistance
- State Department of Public Instruction
- State Department of Welfare
- *Hahnemann Medical College
- *Jefferson Medical College
- *University of Pennsylvania School of Medicine
- *University of Pittsburgh School of Medicine
- University of Pittsburgh Graduate School of Public Health

* Organizations not represented at the above February 11 meeting are marked with an asterisk on its list of charter members.

Woman's Medical College

Pennsylvania State College

*American Cancer Society, Pennsylvania Division
American Heart Association, Pennsylvania Chapter
*American Legion

*American Red Cross, Eastern Area
Association of the Junior Leagues of America, Inc.

*4-H Clubs

*Hospital Association of Pennsylvania
League of Women Voters of Pennsylvania
Medical Society of the State of Pennsylvania
National Foundation for Infantile Paralysis, Inc.
Pennsylvania Association for the Blind

*Pennsylvania Council of Churches

Pennsylvania Economy League

Pennsylvania Federation of Business and Professional Women's Clubs

*Pennsylvania Federation of Labor

*Pennsylvania Federation of Woman's Clubs

Pennsylvania League of Nursing Education

Pennsylvania Nutrition Council

Pennsylvania Osteopathic Association

Pennsylvania Pharmaceutical Association

Pennsylvania Public Health Association

Pennsylvania Organization for Public Health Nursing

Pennsylvania State Chamber of Commerce

*Pennsylvania State Dental Society

*Pennsylvania State Nurses Association

Pennsylvania Society for Crippled Children and Adults, Inc.

Pennsylvania Tuberculosis Society

Pennsylvania Welfare Conference

Pennsylvania Citizens Association

*State Association for Health, Physical Education, and Recreation

*Y. M. C. A. of Pennsylvania

CHANGES IN MEMBERSHIP

New (106) and Reinstated (5) Members

ALLEGHENY COUNTY: Joseph N. Arthur, Jr., Glenshaw; Robert J. Baker, McKees Rocks; Lester H. Botkin, Duquesne; James H. Householder, McKeesport; Frederick C. Duffy, James R. Hoon, W. Creighton McClintock, John R. Miller, Daniel E. Natali, Frederick Rock, Louis C. Waller, and Carl M. Worley, Pittsburgh.

BUCKS COUNTY: Paul G. Breneman, Trevoise.

CAMBRIA COUNTY: Lawrence F. Casale, Portage; Thomas M. Dugan, Nanty Glo; William M. Hughes and Harold Schwartz, Johnstown.

CARBON COUNTY: E. Jane Goplerud, Palmerton.

CHESTER COUNTY: Francis A. Harkins, Wilmington, Del.; Harvey L. Pullen, Downingtown.

CLEARFIELD COUNTY: Henry J. Van Valzah, Clearfield.

COLUMBIA COUNTY: Robert J. Campbell, Nescopeck; Thomas E. Patrick, Mifflinville.

CUMBERLAND COUNTY: George W. Ehly, Mt. Holly Springs.

DAUPHIN COUNTY: Melvin D. Mills, Harrisburg.

DELAWARE COUNTY: Albert G. Schran, Drexel Hill; George L. Stark, Media.

ERIE COUNTY: Howard C. Amacher, Joseph W. Blevins, Jerome W. Craft, John F. Drumheller, Milton I. Engel, William L. Hirsch, Melvin W. Modischer, Mary Jane Stern, and Maurice M. Wicklund, Erie; Dunstan D. Gouldthorpe, Wesleyville.

FAYETTE COUNTY: (Reinstated) Matthew P. Ward, Brownsville.

FRANKLIN COUNTY: Ross S. Funch, Blue Ridge Summit.

INDIANA COUNTY: Paul W. Frazer, Heilwood.

LACKAWANNA COUNTY: Albert J. Cross, Richard L. Huber, Paul A. Ryan, Thomas J. Strunk, and Bernard J. Willis, Scranton.

LANCASTER COUNTY: Robert L. Bauer, Intercourse; Robert R. Buch, Mountville; Robert B. Hess, Terre Hill.

LEBANON COUNTY: Marjorie G. Morrison, Cleona.

LEHIGH COUNTY: Robert P. Fenstermacher, Kenneth E. Jones, and George P. Rutt, Allentown; William O. Muehlhauser, Topton.

LUZERNE COUNTY: Peter Ditoro, Pittston; Robert T. Gildea and Wilbert E. Hernandez, Wilkes-Barre; John H. Stunz, Jr., Freeland; Joseph F. Ziemba, Glen Lyon.

LYCOMING COUNTY: John L. Allen, Herbert A. Ecker, Earl R. Miller, Spencer W. Servoss, and Walter A. Shuman, Williamsport.

MONROE COUNTY: William M. Simons, East Stroudsburg.

MONTGOMERY COUNTY: Edward T. Auer and Donald H. Morley, Hatboro; Patrick J. Costello, Bryn Mawr; Harry J. Crits, Albert J. Fingo, and Joseph T. Riemer, Norristown; Reginald W. Pinckney, Willow Grove; Jule R. Rogan, Bridgeport; Manrico A. Troncellito, Ardmore; Eric C. Walter, Spring City.

NORTHAMPTON COUNTY: George S. Barrett, Robert Cohen, Harold M. Holland, and Robert E. Steward, Easton; Alfred O. Boettger, Martin's Creek; Rudolph E. Gosztanyi, Bethlehem.

PHILADELPHIA COUNTY: William S. Armoir, C. Brinley Bland, Garth W. Boericke, Elsie R. Carrington, Edward W. Closson, John P. Emich, Jr., George B. Hobach, John P. Hobach, James W. Leslie, Norman Nixon, John M. Peck, Meyer Perchonock, Karl Salus, Louis H. Schinfeld, Benjamin Shortkroff, Lawrence B. Weiss, and Frederick O. Zillessen, Philadelphia; Raymond Penneys, Baltimore, Md. (Reinstated) Lewis Lehrer, Grimaldo C. Distefano, and Benson Krieger, Philadelphia; William Weiss, Jr., Los Angeles, Calif.

POTTER COUNTY: Robert A. Niles, Roulette.

SCHUYLKILL COUNTY: Melvin L. Reitz, Tower City.

SOMERSET COUNTY: James L. Killius, Berlin; Russell C. Minick, Stoyestown.

VENANGO COUNTY: W. W. Elder, Jr., Oil City.

WASHINGTON COUNTY: J. A. Krosnoff, Bentleyville; Thomas L. Wilfong, Finleyville.

WESTMORELAND COUNTY: John H. Newman, Greensburg.

YORK COUNTY: John L. Getz, Jr., Jacobus.

Transfers (7), Resignations (20), Deaths (14)

ALLEGHENY: *Resignations*—John E. Balter, Stanley Crawford, Francis W. Joyce, J. Edw. Ricketts, Leo S. Strawn, Rachel Weems, Pittsburgh; Bernard H. Cobetto, Pitcairn; Alvin G. Foraker, Atlanta, Ga.; Meyer R. Rosenbloom, Van Nuys, Calif.; John Wozniak, McKeesport. *Deaths*—Guy D. Engle, Wilkesburg (Univ. Pa. '01), Feb. 7, aged 74; Simon H. Ratner, Pittsburgh (Univ. Pgh. '12), Feb. 10, aged 59.

ARMSTRONG: *Transfer*—Harry J. Thompson, Kittanning, from Washington County Society.

BERKS: *Resignations*—Dana S. Crum, New York City; Alexandria Kates and William Kates, Alabama.

BUTLER: *Resignation*—Frank Edwards, Butler.

CAMBRIA: *Resignations*—Adelaide H. Curtis, Delhi, N. Y.; James Jefferson, Johnstown.

CLINTON: *Transfer*—John P. Brant, Lock Haven, from Allegheny County Society.

CUMBERLAND: *Death*—Oliver P. Stoeck, Newville (Jeff. Med. Coll. '81), February 6, aged 93.

DAUPHIN: *Resignations*—Joseph S. Fager, Ardmore; Josiah F. Reed, Harrisburg.

ERIE: *Resignation*—Phil C. Engelskirger, Indio, Calif.

FRANKLIN: *Death*—Fairfax G. Wright, Chambersburg (Univ. Md. '03), February 13, aged 72.

INDIANA: *Death*—Clark M. Smith, Plumville (Ohio Med. Univ. '03), February 10, aged 71.

LACKAWANNA: *Resignation*—William J. Reedy, Omaha, Neb.

LAWRENCE: *Transfer*—William F. Clark, New Castle, from Lehigh County Society.

LEHIGH: *Resignations*—Elizabeth Sherman Ells, Perry Point, Md.; Irving R. Plotnick, Chicago, Ill.

LUZERNE: *Deaths*—Frederick A. Muschlitz, Wilkes-Barre (Jeff. Med. Coll. '11), January 25, aged 62; Homer B. Wilcox, Kingston (Univ. Pa. '01), January 9, aged 72.

MONTGOMERY: *Transfer*—George W. Bland, Cristobal, C. Z., to Medical Association of Isthmian Canal Zone.

PHILADELPHIA: *Deaths*—Andrew Callahan, Philadelphia (Med.-Chi. Coll. '99), February 17, aged 75; Max F. Herrman, Philadelphia (Univ. Pa. '02), February 8,

aged 68; Joseph C. Hess, Philadelphia (Jeff. Med. Coll. '24), February 4, aged 56; M. Clayton Thrush, Philadelphia (Med.-Chi. Coll. '01), January 17, aged 74.

POTTER: *Death*—Ruth P. Mosch, Coudersport (Univ. Pa. '46), February 2, aged 27.

SCHUYLKILL: *Transfer*—Norman M. Wall, Pottsville, from Allegheny County Society.

SUSQUEHANNA: *Death*—William J. Condon, Susquehanna (New York Univ. Med. Sch. '02), January 3, aged 74.

VENANGO: *Transfer*—John C. Wilkins, Los Angeles, Calif., to Los Angeles County Medical Society. *Resignation*—Samuel A. Marshall, Polk. *Death*—Paul E. Cunningham, Franklin (Univ. Pgh. '10), February 10, aged 64.

WESTMORELAND: *Transfer*—Edward L. Ringer, Monessen, to Logan County (Ill.) Medical Society.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Beaver County	\$125.00
Woman's Auxiliary, Berks County, a friend, in memory of Dr. E. C. Boots	5.00
Woman's Auxiliary, Butler County	50.00
Woman's Auxiliary, Bradford County	70.40
Woman's Auxiliary, Cambria County	175.00
Woman's Auxiliary, Cumberland County	37.00
Woman's Auxiliary, Dauphin County	250.00
in memory of Mrs. A. H. Simmons	10.00
a friend, in memory of Mrs. Simmons	10.00
Woman's Auxiliary, Delaware County, a friend, in memory of Dr. E. C. Boots	5.00
Woman's Auxiliary, Elk-Cameron County	32.00
in memory of Dr. J. B. Mosser	7.00
Woman's Auxiliary, Fayette County	150.00
Woman's Auxiliary, Franklin County	
in memory of Dr. F. G. Wright	5.00
friends, in memory of Dr. Wright	25.00
Woman's Auxiliary, Indiana County	
in memory of Dr. Clark M. Smith	10.00
honoring Mrs. Drury Hinton	5.00
Woman's Auxiliary, Lackawanna County	460.00
Woman's Auxiliary, Lebanon County	150.00
Woman's Auxiliary, Lycoming County	300.00
Woman's Auxiliary, Mifflin County	45.00
Woman's Auxiliary, Montour County	50.00
Woman's Auxiliary, Montgomery County	
a friend	100.00
Woman's Auxiliary, Northumberland County .	60.00
Woman's Auxiliary, Schuylkill County	
in memory of Mrs. Wm. H. Walters and Mrs. Laura Dirschedl	20.00
North of the Mountain Branch	19.00

Woman's Auxiliary, Westmoreland County ..	\$200.00
friends, in memory of Dr. E. C. Boots	10.00
New Kensington Branch	100.00
Previously reported	281.45

Total contributions since 1949 report\$2,766.85

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since February 1. Figures in first column denote county society numbers; second column, State Society numbers.

Feb. 1	Cambria	10, 19	2061-2062	\$46.00
	Cambria	1, 9, 11-18,		
		20-46	2063-2106	1,012.00
	York	103-107	2107-2111	115.00
	Crawford	1-16	2112-2127	368.00
2	Chester	60-66, 68	2128-2135	184.00
	Luzerne	44-90	2136-2182	1,081.00
	Lebanon	38-44	2183-2189	161.00
3	Fayette	121	10759	15.00
	Schuylkill	1-40	2190-2229	920.00
	Dauphin	93-104,		
		106-141	2230-2277	1,104.00
	Allegheny	715-771,		
		773-837	2278-2399	2,806.00
6	Lancaster	1-149	2400-2548	3,427.00
	Lackawanna	79-86	2549-2556	184.00
	Delaware	138-168	2557-2587	713.00
	Berks	145-165	2588-2608	483.00
	Bucks	52-56	2609-2613	115.00
	Somerset	4-12	2614-2622	207.00
	Butler	33-36	2623-2626	92.00
	Lackawanna	63-78	2627-2642	368.00
	Cambria	59, 64	2643-2644	46.00
	Susquehanna	1-11	2645-2655	253.00
	Wayne-Pike	2-10	2656-2664	207.00
	Montgomery	1-33,		
		35-119	2665-2782	2,714.00
7	Cumberland	28-30	2783-2785	69.00
	Northumberland	25-50	2786-2811	598.00
	Northampton	104-126	2812-2834	529.00
	York	108-115	2835-2842	184.00
	Lawrence	10-48, 50-56	2843-2888	1,058.00
8	Columbia	25-30	2889-2894	138.00
	Clarion	1-16	2895-2910	368.00
	Clinton	16-22	2911-2917	161.00
9	Clearfield	31-35	2918-2922	115.00
	McKean	15-19	2923-2927	115.00
	Mercer	21-40	2928-2947	460.00
	Dauphin	142-169	2948-2975	644.00
	Luzerne	91-117, 119-153	2976-3037	1,426.00
	Chester	69-73, 75-79	3038-3047	230.00
10	Blair	1-60	3048-3107	1,380.00
	Tioga	1-12	3108-3119	276.00
	Carbon	1-23	3120-3142	529.00
	Franklin	57-62	3143-3148	138.00
	Lackawanna	87	3149	23.00
	Cambria	87	3150	23.00

Feb. 10	Lehigh	1-129	3151-3279	\$2,967.00	Feb. 25	Lackawanna	150-154	5769-5773	\$115.00
	Lackawanna	88-103	3280-3295	368.00		Perry	1-11	5774-5784	253.00
	Philadelphia	13-22	3296-3305	230.00		Jefferson	42-44	5785-5787	69.00
	Philadelphia	3248-3256	10760-10768	105.00		Schuylkill	41-79	5788-5826	897.00
13	Philadelphia	23-1527	3306-4810	34,615.00		Venango	33-36	5827-5830	92.00
	Montgomery	163-179	4811-4827	391.00		Cambria	102-118	5831-5847	391.00
	Huntingdon	1-21	4828-4848	483.00		Beaver	1-98	5848-5945	2,254.00
	Indiana	26-31	4849-4854	138.00		Crawford	25-41	5946-5961	368.00
	Delaware	43, 169-192	4855-4879	575.00	27	Fayette	21-60	5962-6001	920.00
	Jefferson	29-41	4880-4892	299.00		Carbon	24-28	6002-6006	115.00
	Chester	80-83	4893-4896	92.00		York	125-136	6007-6018	276.00
	Somerset	13-15	4897-4899	69.00		Berks	187-198	6019-6030	276.00
	Cumberland	31-36	4900-4905	138.00		Cambria	119	6031	23.00
	York	116-124	4906-4914	207.00		Franklin	63-72	6032-6041	230.00
	Crawford	17-24	4915-4922	184.00		Mifflin	1-23	6042-6064	529.00
	Erie	1-125	4923-5047	2,875.00		Delaware	207-223	6065-6081	391.00
	Erie	Affiliate		11.50		Greene	1-8	6082-6089	184.00
	Northampton		5048-5066	437.00		Warren	32-43	6090-6101	276.00
14	Northumberland	51-56	5067-5072	138.00		Mercer	59-63, 65-69	6102-6111	230.00
15	Westmoreland	64-119,				Butler	42-46	6112-6116	115.00
		121-133	5073-5141	1,587.00		Wayne-Pike	11-17	6117-6123	161.00
	Montgomery	180-189	5142-5151	230.00		Blair	61-77	6124-6140	391.00
	Armstrong	30-33	5152-5155	92.00		Bucks	66-67	6141-6142	46.00
	Lackawanna	104-135	5156-5187	736.00		Lebanon	55	6143	23.00
	Cambria	47-58, 60-63,				McKean	35-37	6144-6146	69.00
		65-86, 88-102	5188-5240	1,219.00		Lancaster	150-186	6147-6183	851.00
16	Lycoming	1-3, 6	5241-5244	92.00		Bradford	1-29	6184-6212	667.00
	Fayette	1-3	5245-5247	69.00		Lehigh	130-169	6213-6252	920.00
	Lebanon	45-50	5248-5253	138.00		Northampton	160-170,		
17	Bucks	57-61	5254-5258	115.00			228-232	6253-6268	368.00
	Venango	1-10, 12-32	5259-5289	713.00		Washington	57-112	6269-6323	1,265.00
20	Berks	166-186	5290-5310	483.00	28	Washington	113-114	6324-6325	46.00
	Delaware	193-195,				Carbon	29	6326	23.00
		197-205	5311-5322	276.00		Erie	156-171	6327-6342	368.00
	Luzerne	118, 154-188	5323-5358	828.00		Centre	1-21	6343-6363	483.00
	Montgomery	190-201	5359-5370	276.00		Centre	37	10769	15.00
	Huntingdon	22-24	5371-5373	69.00		Lebanon	56-62	6364-6370	161.00
	Butler	37-41	5374-5378	115.00		Chester	92-94	6371-6373	69.00
	Lebanon	51-54	5379-5382	92.00		Montour	20-35	6374-6389	368.00
	Northampton	145-159,				Fayette	61-75	6390-6404	345.00
		227	5383-5398	368.00		Lycoming	107-108	6405-6406	46.00
21	Mercer	41-58	5399-5416	414.00		Schuylkill	80-105	6407-6432	598.00
	Erie	127-155	5417-5445	667.00		Montgomery	202-219	6433-6450	414.00
	Somerset	16	5446	23.00		Crawford	41-43	6451-6453	69.00
22	Dauphin	170-204	5447-5481	805.00		Cambria	120-130	6454-6464	253.00
	McKean	20-34	5482-5496	345.00		Cumberland	39-44	6465-6470	138.00
	Indiana	32-35	5497-5500	92.00		Northampton	171-174	6471-6474	92.00
	Cumberland	37-38	5501-5502	46.00		Columbia	37-41	6475-6479	115.00
	Bucks	62-65	5503-5506	92.00		Tioga	20-21	6480-6481	46.00
	Westmoreland	134-148	5507-5521	345.00		Clarion	17	6482	23.00
	Wyoming	1-9	5522-5530	207.00		Bucks	68-70	6483-6485	69.00
23	Fayette	4-20	5531-5547	391.00		Washington		6486-6487	46.00
	Luzerne	189-221	5548-5580	759.00		Fayette	76-83	6488-6495	184.00
	Bedford	1-6	5581-5586	138.00		Wyoming	10	6496	23.00
	Potter	1-9	5587-5595	207.00		Wayne-Pike	18	6497	23.00
	Lackawanna	136-149	5596-5609	322.00		Washington	115-120	6498-6503	115.00
24	Tioga	13-19	5610-5616	161.00		Warren	44	6504	23.00
	Columbia	31-36	5617-5622	138.00		Venango	37-41	6505-6509	115.00
	Monroe	1-33	5623-5655	759.00		Somerset	17-18	6510-6511	46.00
	Chester	67, 74, 84-91	5656-5665	230.00		Northampton	175-181	6512-6518	161.00
25	Lycoming	7-12, 14-102	5666-5766	2,323.00		Lycoming	109-113	6519-6523	115.00
	Clearfield	37-38	5767-5768	46.00		Montour	36-38	6524-6526	69.00

Feb. 28	Lebanon	63-68	6527-6532	\$138.00
	Lackawanna	155-196	6533-6574	966.00
	Juniata	6	6575	23.00
	Fayette	84-91	6576-6583	184.00
	Elk	2, 4-8	6584-6589	138.00
	Delaware	224-230	6590-6596	161.00
	Clearfield	39-43	6597-6601	115.00
	Cumberland	45-48	6602-6605	92.00
	Clarion	18	6606	23.00
	Carbon	30-35	6607-6612	138.00
	Cambria	131-137	6613-6619	161.00
	Bradford	30-35	6620-6625	138.00
	Armstrong	34-38	6626-6630	115.00
	Adams	1-25	6631-6655	575.00
	Dauphin	205-249	6656-6700	1,035.00
	York	144-151	6701-6708	184.00
	Greene	9-17	6709-6717	207.00
	Wayne-Pike	19	6718	23.00
	Crawford	44-46	6719-6721	69.00
	Berks	199-221	6722-6744	529.00
	Indiana	36-38	6745-6747	69.00
	Luzerne	222-224	6748-6770	529.00
	Wayne-Pike	20-21	6771-6772	46.00
	Montgomery	220-247	6773-6800	115.00
	Cambria	138-142	6801-6805	115.00
	Lancaster	187-214	6806-6833	644.00
	Northumberland	57-66	6834-6843	230.00
	Chester	95-101	6844-6850	161.00
	Erie	172-193	6851-6872	506.00
	Butler	47-51	6873-6877	115.00
	Delaware	206, 231-247	6878-6895	414.00
	Franklin	73-75	6896-6898	69.00
	Bradford	36-40	6899-6903	115.00
	Philadelphia		6904-7483	13,340.00
	Somerset	19-21	7484-7486	69.00
	Washington	121-125	7487-7491	115.00
	Luzerne	245-310	7492-7557	1,518.00
	Luzerne	370-372	10770-10772	45.00
	Elk	9-18	7558-7567	230.00
	Bucks	71-74	7568-7571	92.00
	Chester	102-105	7572-7575	92.00
	Allegheny	838-1463	7576-8201	14,398.00
	Susquehanna	12-13	8202-8203	46.00
	Allegheny		8204	11.50
	Clarion	19-22	8205-8208	92.00
	Lackawanna	206-211	8209-8214	138.00
	Tioga	22	8215	23.00
	Butler	52	8216	23.00
	Susquehanna	14	8217	23.00
	Delaware	196, 251-254	8218-8222	115.00
	Montgomery	120-162,		
		248-260	8223-8278	1,288.00
	York	152-154	8279-8281	69.00
	Berks	222-228	8282-8288	161.00
	Lackawanna	197-205,		
		212, 213	8289-8299	253.00
	Warren	45-46	8300-8301	46.00
	Wayne-Pike	22	8302	23.00

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There has been a continuous increase in the usage of this service, which proves that it has served our physicians well.

The following requests were filled during the month of February:

Penicillin sensitivity	Retroperitoneal cysts
Cardiac catheterization	Achrestic anemia
Buerger's disease	Periarteritis nodosa
House dust	Laminography
Anaphylaxis and allergy	Planigraphy
Toxicity of tobacco	Tomography
Otorhinolaryngology	Collagen disease
Care of the aged	Blastomycosis
Rh factor (3)	Paget's disease
Electrocardiography	Blood coagulation
Silicosis	Physicians' office setup
Biopsy	Botanic medicine
Cancer	Animal experimentation
Medicine in Great Britain	Tuberculosis
Socialized medicine	Histamine headache (2)
Carcinoma of the cervix	Hospitals
Serodiagnosis of syphilis	Medical economics (2)
Cancer of the larynx	Antihistaminics
Nutrition in surgery	Priapism
Cold allergy	External biliary fistula
Scleroderma	Goiter
Skin cancer	Aberrant thyroid
Premarital education	Cancer
Sex education	Pericarditis
Adaptation syndrome (4)	Prevention of abortion
Trichomonas vaginalis	Excretion of pregnandiol
Blood banks	Public health service
Preventive medicine (3)	Abortion
Cancer mortality	Hernia
Cancer of the breast	Arachnoiditis
Pelvic examination	Psychosomatic medicine
Diagnosis of cancer	Locum tenens
Lipoidosis	Fistulas
Biopsy of the liver	Asthma therapy
Hyperparathyroidism	State medical societies
Psychiatry	Psychiatric hospitals
Penicillin	Psychotherapy
Appendicitis mortality	Use of ACTH
Use of protein	Tumors of the neck
Bone marrow	Plans for medical service
Treatment of cancer of the head and neck	
Carcinoma of the corpus uteri	
Peripheral vascular disease (2)	



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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

WITH the tuberculosis death rate dropping so rapidly, the question is sometimes asked why larger amounts are needed each year for the control of this disease. The answer, in a nutshell, is that eradication of tuberculosis in this country within a relatively few years is now the goal. In the past the best that one could attempt was to keep the disease under control. It now appears that, with the concentrated effort of all interested groups, tuberculosis may be conquered in most communities in the foreseeable future.

TUBERCULOSIS—THE COSTLY DISEASE

If tuberculosis is to be eradicated, adequate facilities must be made available for chest x-rays of all apparently healthy adults, for suitable follow-up of all cases needing further study, and for medical care.

Sufficient hospital beds must be made available to insure care and isolation for all persons with active disease; adequate financial provision must be made for the families of hospitalized patients; and funds must be at hand to insure the rehabilitation of ex-patients. Above all, health education must be carried to a far greater proportion of the population. Medical research must continue on many fronts. Pensions must be provided for tuberculous veterans. All these facilities and activities require vast sums of money both from official and voluntary sources.

Best estimates indicate that in 1948 the tuberculosis control program in the United States cost approximately 350 million dollars. This amount makes no allowance for hospital construction, for depreciation of hospital buildings, or for the training of professional personnel.

The Public Health Service appropriation for tuberculosis control is now about ten million dollars annually; the Christmas Seal sale is more than 20 million dollars; state health department funds for tuberculosis work have increased materially in the past decade. The Veterans Administration is now spending much

more on hospitalization and rehabilitation of the tuberculous. Pensions for veterans whose major disability is tuberculosis amounted to 86 million dollars in the calendar year 1947.

Not only are official and voluntary health agencies spending huge amounts on community-wide x-ray surveys but industrial firms and labor unions are financing projects of this type. Moreover, in recent years it has become necessary to devote large sums to the recruitment and training of executive and professional health workers.

In addition to the estimated annual cost of approximately 350 million dollars, so-called "hidden costs" of tuberculosis run well into the hundreds of millions. Among these costs are the potential annual losses in wages, in production, and in net future earnings incurred by those persons who die or are incapacitated by tuberculosis. Since these estimates overlap to some extent, no total can be shown for potential losses of this type.

A study made in 1943 estimated that the potential loss of wages in that one year by those who were ill or who died of tuberculosis was nearly 200 million dollars. The potential loss of goods and services which might have been produced in that year was 350 million dollars. There is, in addition, a potential loss in the net future earnings of those who died in 1943 which came to more than 200 million dollars.

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- subcutaneous tissues
- dermatologic state
- urinary riboflavin output
- musculature
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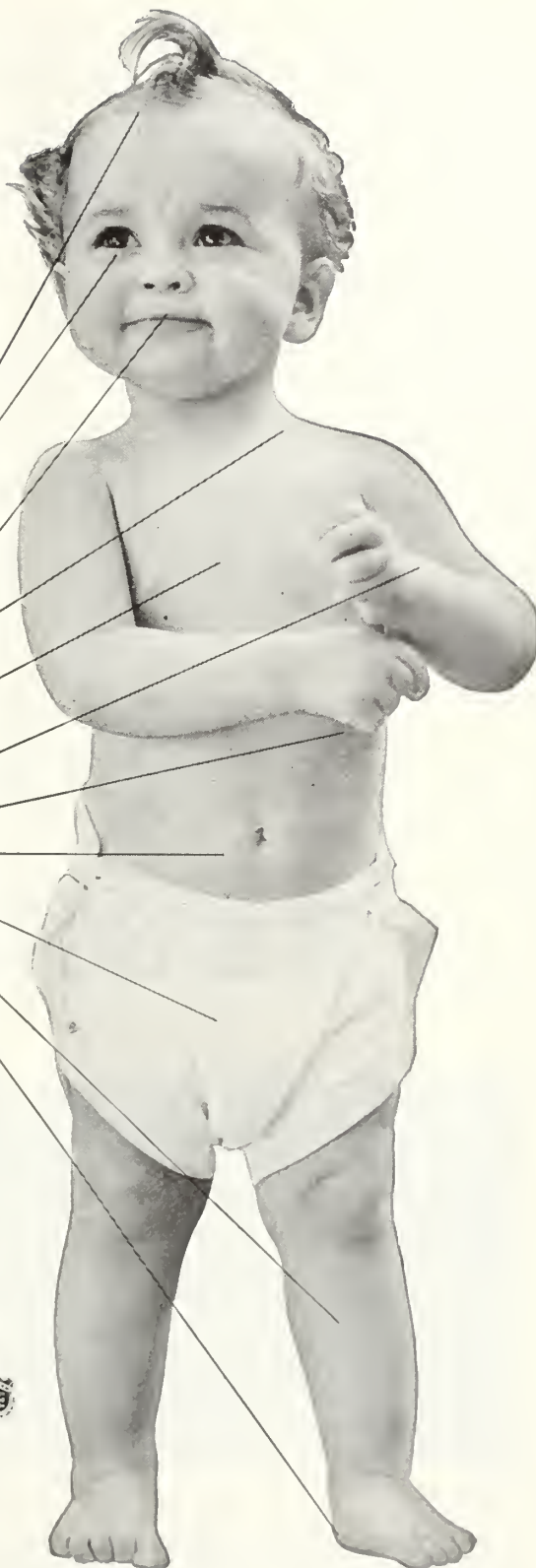
1. "A Study of Enriched Cereal in Child Feeding" Urbach, C.; Mack, P. B., and Stokes, Jr., J. Pediatrics 1:70, 1948.

*Cerevim contains neither vitamin A nor C but possibly exercises an A-and-C sparing effect attributed to its high content of protein and major B vitamins.

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None of these estimates makes any allowance for the cost of the many thousands of new beds needed. This cost would come to approximately 200 million dollars for about 40,000 new beds; if the 80,000 beds, said by certain authorities to be needed, were to be built, the estimated cost would be 400 million dollars. Such an enormous outlay may be considered justified, even in the face of a rapidly falling tuberculosis death rate, since at the end of a decade or two the hospitals would be available for chronic disease patients. Such facilities will become increasingly necessary since our population is aging rapidly. Moreover, in view of accelerated world travel, it will still be necessary some years hence to appropriate a moderate amount to maintain hospital and other facilities for tuberculosis control.

The tuberculosis death rate has now dropped to 30 per 100,000 population in the country as a whole, compared with a rate of 194 in 1900. The sensational decline in the over-all mortality rate from this disease during the past five decades has tended to obscure the fact that the death rate varies widely according to sex, age, color, economic status, and locality. Thus, the death rate of 30 must be accepted as an average only.

Mortality from tuberculosis is twice as high among men as among women. It increases directly with age and is especially high among older men. The death rate among Negroes is three times as high as among white people. In one state the death rate is still 100, while one or two states now have rates of less than 10. Similarly, a few of our large cities have outstandingly high rates. Mortality is seven times as high among unskilled laborers as among professional persons. Thus it is evident that in numerous groups a great deal of concentrated effort must be exerted if the disease is to be brought under control at any time in the near future.

For all these reasons, the cost of tuberculosis control cannot be lessened in any community until its tuberculosis death rate reaches a level of less than 10 per 100,000. When that goal is attained, it is possible that much of the available funds may be diverted to other phases of health work. Until then, no letup can be planned.

Editorial, Mary Dempsey, Statistician, National Tuberculosis Association, Bulletin of the National Tuberculosis Association, December, 1949.

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*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

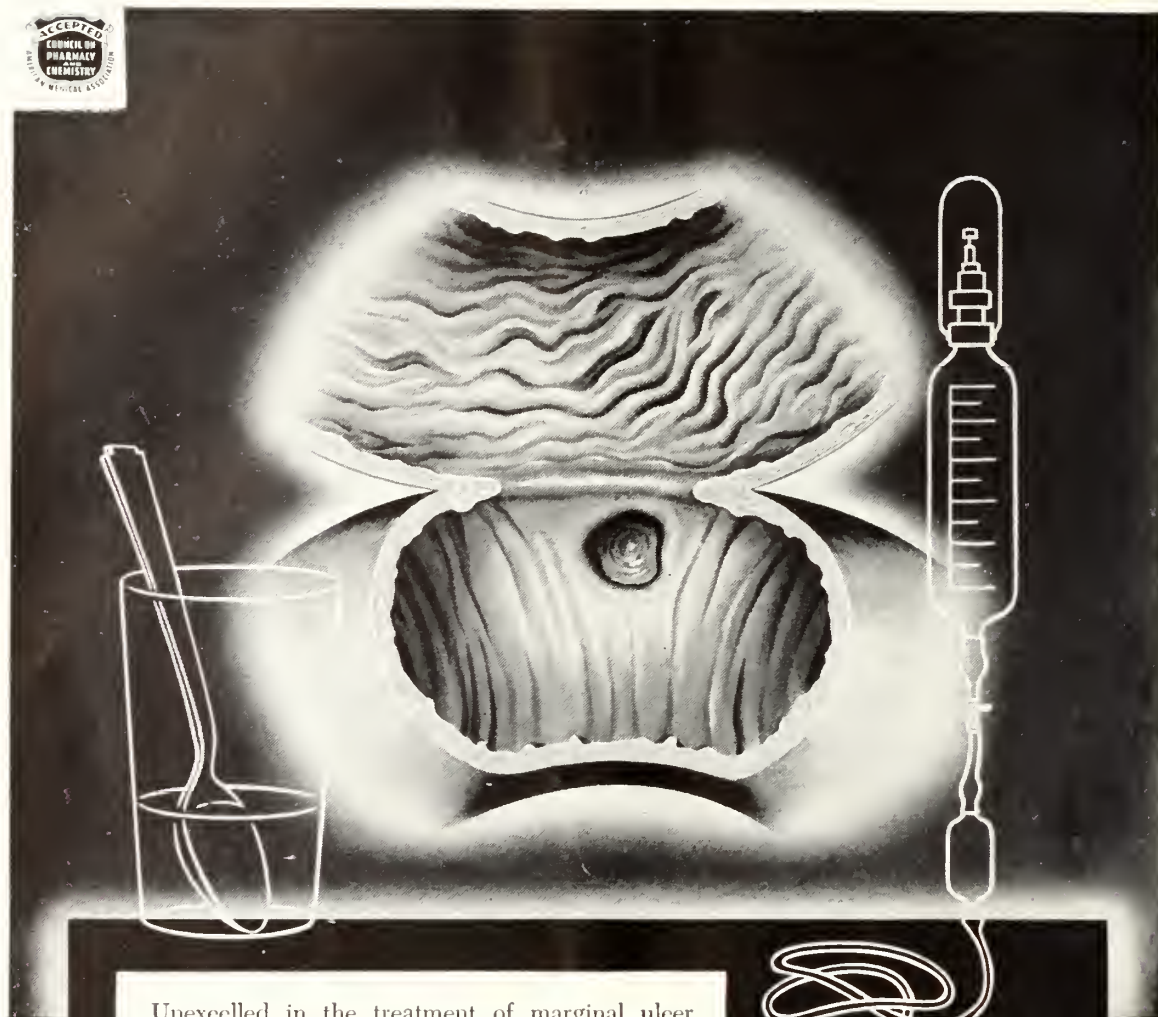
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KEYSTONES OF PUBLIC HEALTH FOR PENNSYLVANIA

A Progress Report

GEORGE S. KLUMP, M.D.

Williamsport, Pa.

The survey report known as *Keystones of Public Health for Pennsylvania* has examined the character and effectiveness of administrative procedures, personnel setup, financial structure, and activities of the Pennsylvania Department of Health. It includes a rather complete study of the central office activities and a rather limited study of 1808 local health jurisdictions under state control. An intensive study was made of Lancaster and Luzerne counties, while a less intensive study was made of Westmoreland County. The cities of Philadelphia and Pittsburgh were not included in the survey.

The survey has sought to discover what health services are provided for the people of Pennsylvania—where, how much, how and by whom, what they cost, and how adequate and effective these services are.

This discussion will deal briefly with your personal stake and that of your community in the survey, two of the eight keystones, and what is being done to keep the survey alive. You should remember that it went over term; it was nearly stillborn; and it is your baby.

The Survey and the Surveyors

The House of Delegates of The Medical Society of the State of Pennsylvania in September, 1947, by official action, urged and approved the inauguration of such a survey. The request to the American Public Health Association was made by Governor Duff and Secretary of Health Vaux. The request was received and approved by the association's Subcommittee on State and Local Health Administration of the Committee on Administrative Practice. This subcommittee

has conducted state studies for over ten years on the theory that one of the most dependable means of improving local health services is to provide effective state health departments. The field staff is experienced and considered tops in this field. Besides the staff, some thirteen consultants were requested to work on various chapters of the survey. Financial support came from a private source, the Commonwealth Fund, and from tax monies supplied by the Department of Health.

It is a fine job of research done by a qualified team. The conclusions and recommendations are based on facts. Many a fine piece of research has been pigeonholed because someone did not like the facts. *Keystones of Public Health for Pennsylvania* deserves a better fate than that.

What Is Your Stake?

Political power and the power of the purse have been increasingly concentrated in larger and larger units of government, a trend which is currently being called "statism." At the Federal level Pennsylvania's share of the proposed 1950 budget is over 3200 million dollars. But statism is not confined to the Federal government by any means; it has been a feature of our commonwealth for many years.

If you are an average fellow, you are working from Monday morning to Tuesday noon to pay your local, state, and Federal taxes. Over 40 per cent of your state tax dollar is spent on public health and welfare. You want your money's worth. There may be, there is, an even more compelling reason for your interest.

Keystones of Public Health for Pennsylvania tells you important facts about your own county that are fundamental to health and good citizenship. Action depends upon conviction, and conviction in turn depends on understanding.

The Keystones

A study designed to improve any phase of health services to the people is likely to stress those areas in which improvement is possible. Indeed, that is the primary purpose of such a survey. This emphasis on what needs to be done

Presented at the fourth annual conference of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania in Harrisburg, March 9, 1950, and at the thirty-eighth annual Conference of Secretaries and Editors in Harrisburg, March 3, 1950.

might seem to imply that excellent service in other fields is not being rendered, and this is not necessarily true.

It should be recognized that any survey may easily sketch in broad terms what ought to be done; the real difficulty is how to do it. The task usually can be done only the hard way—by the patience, work, and understanding cooperation of those interested enough to try. We need everyone's assistance, but we especially need the help of the many conscientious administrators and employees of the Department of Health.

This survey has scores of recommendations and, as stated in the foreword of the report, it would indeed be a miracle if all were sound. There are eight "keystones" which blaze the trail and there are documentary highway markers at every turn.

The keystones I want to discuss with you are the two which have been approved by the 1949 House of Delegates of The Medical Society of the State of Pennsylvania. They are numbers 4 and 6.

Number 4 reads as follows: "A merit system applied to all public health personnel which will include the best modern practices in recruitment, methods of selection, permanence of employment, equality and adequacy of pay, impartial treatment, and provisions for economic security upon retirement."

Number 6 reads as follows: "The establishment of local health units in counties, cities, or other municipalities or in combinations thereof."

The Merit System

Improvement in the public health program is fundamentally dependent on a program of personnel administration based on merit.

The Social Security Law amendment of 1939 required a merit system for selection of employees in departments utilizing Federal funds. There has been some activity by the Civil Service Commission, to be sure, but about 90 per cent of the workers are officially selected under the patronage system. There is no qualified personnel director for either the Commission or the Department of Health. Even after selection of a name from the Civil Service list, that person must be sponsored by the proper party official, usually the applicant's county chairman. It doesn't matter which major party is in power—both Democrats and Republicans have adopted this system.

Before proceeding with further comment regarding political activity in the Department, it should be made crystal clear that there is nothing wrong with the concept of politics as "the science of art of political government," for we live under a two-party system. In the proper functioning of such a system lies the only true liberalism. There is nothing wrong with partisan politics if the adherents of the party work in the public interest and if they be statesmen.

In 1935, and again in 1939 when party control changed, there were dismissals that totaled practically 100 per cent of the workers. A few key persons were reappointed after a few weeks, but were subject to re-registering and to party donations.

In a random examination of the personnel files of recent appointments supported by photostats, evidence of political activity was found in about half and this was true in all types of jobs.

Of the 13 major industrial states, Pennsylvania is the only one without state-wide merit system coverage. Pennsylvania is the only state in the Union without merit system coverage for all health department employees.

The difficulty in securing well-trained career health personnel under these circumstances is self-evident. The Department has been fortunate in having loyal, experienced, top level administrators who, in spite of the methods they have had to employ, have done a good job and provided inspiring leadership.

It is necessary that our political leaders appreciate the value of a well-rounded, efficiently administered public health program and then use their power to implement it. At this time there is nothing to suggest any great enthusiasm on the part of the politicians of either major party for such an enlightened approach.

It is part of our job to demonstrate that enlightened politics or statesmanship can be smart politics. When the people know the truth, they will see to it that their health interests are served. This is their case as well as ours—even more than ours—so let us tell the story. Once it is understood by the people, there can be no doubt regarding bipartisan sponsorship for an honestly administered merit system.

Local Health Units

The establishment of local health units with the responsibility and authority to develop gen-

uine and complete public health services is clearly indicated.

There are three basic sources of funds and services:

1. The state, including Federal monies.
2. Local government — municipalities and school districts.
3. Voluntary agencies.

All three are operative in varying proportion in all counties of the Commonwealth. No one of the three groups is supplying full health services in any one of the activities usually included in a public health program.

The obligations fixed by law include that of the Department of Health to, and these are the words: ". . . protect the health of the people of this Commonwealth. . . ." However, there are other statutes, each different, applying to first-class cities, second-class cities, third-class cities, and boroughs and first-class townships.

There are differing responsibilities under different statutes. The responsibility for administration of health services in second-class townships remains primarily with the State. There is a similar pattern in the school districts.

To further complicate the administrative system, there are usually at least ten units of the department operating in a county essentially as separate agencies. This type of vertical administration, through separate bureaus and divisions, is exemplified by an instance in which reports went from the front of a building to the rear of the building by the way of Harrisburg.

Only 16 health jurisdictions of the more than 2500 municipalities in the State have populations over 50,000, which is considered the minimum population to be served efficiently and economically by a local health unit. Some administer to as few as 80 citizens.

The State provides some health services regardless of local responsibilities and has made little serious effort to strengthen local services.

An example of the complexity of administration of health services in the present pattern is furnished by Luzerne County where funds for public health are provided, handled, supervised, and spent under policies formulated by over 100 agencies as follows:

State (separate administrative units)	14
Voluntary agencies	18

Municipalities	40
School districts	29

In addition to state employees who serve on a multi-county basis, these agencies or units employ 184 full-time and 333 part-time persons.

Such a pattern almost excludes the possibility of maximum efficiency or of a well-planned program or even a group of programs designed to meet known problems of the county by the best known methods of public health.

The Department's services are, of course, entitled to be judged by results and not by the administrative pattern, but an important conclusion of the survey is that results are not adequately known. This in itself is adjudged a major failure of the service.

The local public health unit has been approved by the American Medical Association, the American Public Health Association, and at least three score other national agencies representing 50,000 local organizations.

In considering how this integrated local unit may be developed in Pennsylvania from the present complex pattern, it is evident that such development is a relatively long-range project. One of the first steps is simplification and codification of the laws relating to public health. Such a survey is now under way at the University of Pittsburgh.

Pennsylvania is one of six states that do not have either permissive or mandatory county or district health unit legislation. Such legislation is now under study by The Medical Society of the State of Pennsylvania and other interested groups.

The two keystones discussed provide for competent personnel and sound organization. Surely these are minimal requirements. Can we afford not to have them?

Responsible citizens are daily becoming more and more concerned with the rising costs of government. Would provision of complete local public health services add to the total cost? In my opinion there is definite need for an objective answer to this question. Page 31 of the Survey contains these words: "The survey staff does not recommend an increase in budget until the department is reorganized and its efficiency increased. . . ."

One may observe, however, that many other states with less resources than Pennsylvania, have had of necessity to adopt a more economical

and efficient system than we now employ and that most of the successful ones, irrespective of methods of financing, provide public health services by a unit.

Education and Implementation

What is being done?

Most of the voluntary health agencies have looked to The Medical Society of the State of Pennsylvania for leadership, and I, as one vitally interested in the survey, have looked to these agencies for not only leadership but inspiration. They have volunteer boards of directors of the highest caliber—just the same as our active and alert members who serve on the committees of The Medical Society of the State of Pennsylvania.

The Pennsylvania Citizens Association (formerly Public Charities Association) and the Pennsylvania Tuberculosis and Health Society are cooperating in producing a digest which will be available soon. Both organizations have carried full discussions in their official publications and have assigned committees to work toward implementation of the recommendations through education of each citizen.

There has been need and demand for additional copies of the Survey. The Board of Trustees of The Medical Society of the State of Pennsylvania has agreed to underwrite 300 of 1000 additional copies. We need them for our own committees and to distribute them to members of the next State Legislature.

The Commission on Preventive Medicine and Public Health of the State Society has assigned chapters of the Survey to its members for study and report; editorials, previously approved by the entire commission but written by assignment, are now appearing each month in THE PENNSYLVANIA MEDICAL JOURNAL.

The commission is also actively investigating the feasibility of developing visual aids for the presentation of material in the Survey. It has assigned the chapters of the Survey to the appropriate committees or commissions of the Society for study and report to the Board of Trustees. It has alerted the Committee on Public Health Legislation to the need for prompt study of needed legislation.

On Jan. 8, 1950, at a joint meeting of the chairmen of committees and commissions of the Medical Society, with a special committee of the Pennsylvania Tuberculosis and Health Society,

and representatives of the Pennsylvania Citizens Association and the Pennsylvania State Health Council, it was the consensus that:

1. Emphasis should be on the "merit system" and "local health services" keystones.
2. The Pennsylvania State Health Council be the correlating body in having the report studied.
3. A committee be appointed by Dr. Lucchesi to seek an audience with the Governor and the Secretary of Health to inquire in what way we may help and what they are prepared to do now.

Some of our members may say: "Appointing committees and assigning jobs to councils looks just like the usual way of passing the buck and kicking the problem upstairs. Anyway, there are things in that Survey that could hurt us or our friends, so why not let well enough alone? After all, who is going to read it?"

I would certainly agree that there is little value in writing and publishing any document such as the Survey unless there is also a call to action. The call to action is loud and clear, not only in the documentation of the Survey itself but also from many other sources. The problems raised and the tentative solutions offered are not limited to public health alone. They involve the state constitution and the structure of local government. Fundamentally, they are linked with one's own social philosophy. Do you, as a citizen of this Commonwealth, want a stronger local government? Do you? Governments don't think, committees don't think—only individuals think.

Integrity and conscience and judgment are the distinctive and exclusive properties of you as an individual citizen. In a large measure the fate of this survey depends on you as an individual.

You don't need a new committee—you are it. Concentrate on the two keystones approved by our own House of Delegates. All the indoctrination you need is in the introduction and the first four chapters—58 pages, 13 of which are charts. Five of the eight keystones are in the recommendations of the first chapter. They are reiterated again and again in the 300 following pages.

The voluntary health organizations are looking to the county medical societies and their auxiliaries for leadership, for speakers and, even more important, for informed technical resource people. You are a technical expert to the laity

and you *could* be an expert on the Survey contents with minimal effort.

Here is an opportunity for community service that is completely unselfish. Here is a public relations program that is tailor-made for you, yet it's hanging on the rack. Why not try it on?

Health is a function of the community's total way of life. It is essential that the public be informed on the actual progress toward sound public health planning. The furtherance of health is dependent upon local understanding, local initiative, local support, and participation by the entire community.

Here are intricate and interrelated problems which will require good will, good faith, perseverance, hard work, and high statesmanship for their solution.

Overdramatic as the words may sound, the objective must be to achieve health for not only the individual but for society itself. It is a question on which every responsible citizen must take a stand, for its answer may well affect our whole destiny. And if you think I'm waving the flag, you're right!

PRESIDENT'S MESSAGE



As president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, one has the splendid opportunity to observe firsthand the women who compose the various units of this fine organization. It is not possible to meet several thousand women within a few months without forming some idea as to their type, their background, their interests, and their reasons for being auxiliary members aside from mere eligibility.

A bird's-eye view of our State Auxiliary has given me much to think about and every opportunity to understand why our organization is ever going forward to greater success. Much of this progress is due to the types of women who are actively interested in the Auxiliary. Primarily, the leaders in every county are busy women. They are concerned with many movements for the betterment of their communities, their neighbors, and their children. They are women who enjoy people, who are charitable,



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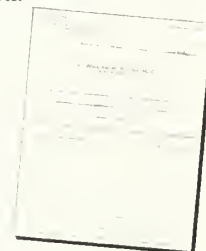


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and who have high ideals. They believe in service to their fellow man and are conscientious in the performance of all tasks assigned to them and responsive to all requests made of them.

Above all, I have noticed that these women of our Auxiliary are inclined to recognize their own human frailties and to ask for and rely upon Superior guidance in the deliberations of their meetings, as well as in their daily living. It is the custom to open all State Auxiliary meetings with prayer, and at many county meetings thanks are offered for spiritual food as well as meat at the table. The habit of recognizing our own insignificance and the need for divine assistance in our work is a healthy attitude among our members and contributes greatly to the successful growth of our organization, to the better understanding of our mutual problems, and to the ultimate solution of trying situations.

We are of all nationalities and religious beliefs, our racial backgrounds are varied and many, yet in the Auxiliary I believe that we become as one in our devotion to service, which is our highest purpose. Because of the beauty and the thoughtfulness of expression in the prayers I have heard

this year at our meetings, I have been encouraged to include some of them in these pages so that all might read them. I believe that with the collaboration of members who can express thoughts such as these we will not fail in any endeavor and the Auxiliary has its feet firmly planted upon the road to success.

Starting with the opening of the first session of the convention in Pittsburgh, when one of our first state presidents opened the meeting with prayer, I submit these for your reading:

"We are a group of women from all parts of our great state. We represent diverse religious faiths; but whether we are Protestants, Catholics, or of the family of Israel, we address our petition to the Great Creator of the universe and the Father of all mankind.

"As we bow before Him, we ask that each one will send up a prayer in her own faith, but together we unite to ask for wisdom and guidance in solving the problems presented in the plans for the coming year.

"Bless the friendships we have made. When we return home at the end of the sessions, with renewed faith and inspiration, may we be true

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"O God, our loving Father, we thank Thee for Thy manifold blessings to us and especially today for the privilege of meeting together in convention and having with us our doctor advisors and those who are caring for the health of the people in our great state. Wilt Thou give them and us strength for each daily task, and courage and wisdom to face the road ahead. Wilt Thou, dear Father, guide them in their efforts to carry out their program for the advancement of medicine and public health. Help us to rally to their side and present a united front for the preservation of free enterprise in medicine.

"We ask Thy blessing upon our fellowship here together. Wilt Thou sustain our bodies with this food, our hearts with true friendship, and our souls with Thy Truth, for Jesus' sake, Amen."—(MRS. WELLINGTON D.) EDITH H. GRIESEMER, Berks County, Tuesday Luncheon, 1949 Convention.

"We pause in quiet reverence to acknowledge that prayer is the soul's sincere desire, uttered or unexpressed, and to ask Thy continued guidance in our daily lives. Bless this food, in Thy name we ask it, Amen."—(MRS. LUTHER M.) MARY L. WHITCOMB, Cumberland County.

"Our loving Father, from whom all blessings flow, we thank Thee, for Thou hast prepared this table before us, in the presence of our friends. As we partake of this nourishment for our bodies, may we be aware that Thou hast also available for our mental and spiritual use the nourishment which we need to discharge our many and complex duties to our families, our communities, and to this our auxiliary to the medical profession.

"May we, in accepting this threefold blessing, feel within us the sustaining and comforting presence of Thy son, our saviour and friend, Jesus Christ. Amen." — (MRS. EDWARD H.) ANGELE S. BEDROSSIAN, Delaware County.

"The eyes of all wait upon Thee, O Lord, and Thou givest them their meat in due season.

"Our Father, whose hand is ever filled with bounty for Thy children, accept our thanks for

the food set before us. We come to Thee because we are children of need. Our minds need Thy illumination, our hearts Thy love, and our bodies Thy bountiful sustenance.

"Oh God, we ask Thy guidance, strength, and help to enable us to perform the tasks which will be presented to us this afternoon.

"We ask Thy blessing upon our homes and our dear ones. Keep us ever near and dear to Thee, in Jesus' name, Amen."—(MRS. C. HENRY) PEARL C. BLOOM, Blair County.

"Dear Father, give us grateful hearts for our blessings, our families, our friends, and the fellowship we enjoy together. Keep us in Thy care that we may meet again. In Jesus' name, Amen."—(MRS. FRANK H., SR.) EDNA M. McNUTT, Armstrong County.

"Dear Lord, please bless this gathering. We thank Thee for this food and pray that Thou wilt nourish it to our bodies. In Jesus' name, Amen."—(MRS. HOWARD F.) ELOISE R. CONN, Fayette County.

"Dear Heavenly Father, we thank Thee for Thy many blessings and divine guidance through our many cares and problems.

"Help us to help others and thus add to the number that are working for unity in this life of ours.

"Bless, O Lord, this food to our good and us in Thy service, we ask in Thy name, Amen."—(MRS. JAMES G.) MARY V. KOSHLAND, Mifflin County.

"Accept, O Father, our humble thanks for this our food as it adds strength to our bodies. May it give us power to render better service to Thee. Be at this table we pray Thee. Bless our gathering together. Especially bless the officers of our Auxiliary and may they be given strength for the task committed unto them. Through Jesus Christ, our Lord, Amen."—(MRS. JOHN) HELEN E. VASTINE, Northumberland County.

(MRS. DRURY) ELIZABETH M. HINTON,
President.

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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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STATISTICS IN CANCER CONTROL*

Being the time of year for inventories and stock-taking, it would seem to be desirable at the beginning of 1950 to review and reappraise the statistical program and activities of the Division of Cancer Control of the Pennsylvania Department of Health.

While the other important projects of the Division, including (1) postgraduate professional education of physicians and dentists on cancer, (2) promotion of and financial assistance to hospital tumor clinics, and (3) grants for special cancer research, are generally recognized as acceptable and standard procedures in any state cancer control program, the value of statistical reporting, collection, coding, and analysis as related to cancer control apparently is subject to some debate, and the methods differ considerably from state to state. To date, many states—as is the case in Pennsylvania—are carry-

* A preliminary report submitted to the Secretary of Health, Commonwealth of Pennsylvania, and the Cancer Commission of the State Medical Society in January, 1950, by Leverett D. Bristol, M.D., Dr. P.H., Chief, and Ada L. Smith, Biometrician of the Division of Cancer Control of the Pennsylvania Department of Health.

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ing on their cancer statistical programs in an "experimental" or "demonstration" manner, hoping that some standard procedure may be worked out in the near future which will be a practicable, feasible, valuable, and economical contribution to the prevention and control of cancer. Cancer control implies the use of sickness or morbidity statistics as well as the study of death records.

In Pennsylvania there are at present two methods of reporting cancer. (1) *required* reporting by all practicing physicians of each diagnosed case of cancer, and (2) *voluntary* reporting by hospitals, 89 out of about 300 of which are cooperating by sending copies of their tumor records for the Central Tumor Registry developed and maintained by the Division of Cancer Control. Approximately 1010 records and 2517 follow-ups per month were received during the last six months of 1949. The required reporting of cancer by physicians, previously done on a postal card and now on a new form in a sealed envelope, is based on a regulation passed originally about ten years ago by the State Advisory Health Board, which is permitted under the laws of Pennsylvania. This new report form was discussed and approved by the Cancer Commission of the State Medical Society on June 1, 1949.

Each method of obtaining statistical data on which to base the cancer studies and program of the Division of Cancer Control of the Pennsylvania Department of Health has its strength and its weakness. In order to determine a wise future policy in this matter of obtaining and using statistical data on cancer morbidity, it was decided to make a brief study of what other states are doing in this regard, and to obtain information as to the value and methods noted and practiced by various state and territorial departments of health. Letters and questionnaires were sent to cancer control officials of 53 states and territories. To date, 44 replies have been received. It is probable that in most of the states not replying little or nothing is being done in cancer control or in the development of a statistical program on a state-wide basis.

Value of Cancer Statistics

There is no point in considering *methods* to be used in any activity unless the *value* of the objectives to be attained is recognized and admitted. Of the 44 states replying to the questionnaire, 21 believe in the value of

required reporting by physicians, and 20 already have put this into effect; 19 states believe in voluntary reporting by hospitals and 16 states consider *both* required reporting by physicians and voluntary reporting by hospitals to be of value. If only one method of reporting is to be followed, 9 states indicate that required reporting by physicians is more valuable, while 11 place more value on voluntary reporting by hospitals. Several of the replies were such that no specific figures could be included in this report.

As to the use to which such statistics should be put, 29 states believe they are of value in connection with the administration of cancer control programs; 33 in stimulating and assisting in scientific research; and 34 in making possible much needed follow-up service for patients. Several of the states also suggest the value of reporting from the standpoints of education of the profession and the public, epidemiologic studies, and evaluation of tumor therapy.

The Division of Cancer Control of the Pennsylvania Department of Health has proceeded for the past three years in the development of its statistical program of cancer morbidity reporting and Central Tumor Registry on the assumption that statistical studies and investigations are an essential part of a cancer control program and that they should be of value in providing: (1) knowledge of the extent of the total cancer problem in the population; (2) information for epidemiologic investigation of the relationship of the different types of cancer to age, sex, race, marital status, occupation, and other factors; (3) a basis for measurement and evaluation of progress in control and treatment of the disease; (4) a basis for estimating the local need for professional and other services and facilities in the care of cancer patients; (5) material useful for both professional and lay education. In addition, the development of statistical services stimulates the improvement of case records and record systems and the follow-up of cancer patients. When sufficient time has elapsed, it will be more possible to evaluate the progress of the cancer statistical program and its relation to control of this disease in Pennsylvania.

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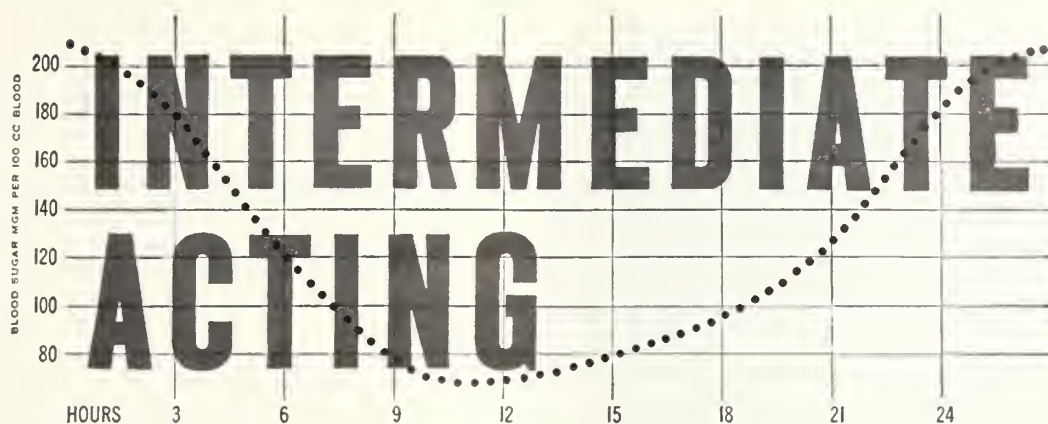
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In addition to the above, many hospitals doing research on their past cases have asked the Division of Cancer Control to check against death reports for such cases. The Division has been able to render this service to a limited degree, but as soon as these death records become more up-to-date, a greater service can be rendered to the hospitals.

Service is rendered to individual Pennsylvania physicians who wish special information or statistics on cancer for scientific papers being written for medical meetings or publications or to evaluate their own experience.

Reporting by Physicians

Of those replying, 22 states and territories, including Pennsylvania, require a report of each diagnosed case of cancer by physicians, while 21 do not. In those in which such a requirement is in effect, 5 are based on a legislative act, and 17, including Pennsylvania, on state department or board regulation. Such reports are sent direct to the state health office in 10 states and to the local health authority in 11. In 4 instances these reports are sent first to the local authority and then forwarded to the state office. In Pennsylvania, at present, these reports are sent direct to the State Cancer Division.

Ten states and territories indicate that these reports are fairly satisfactory, while 9 are not satisfied with the reports. The approximate percentage of physicians now reporting varies from 0 per cent in one state to 85 per cent in one large state with ten years' experience, or an average of 36 per cent for all the states replying. In most instances the percentage is low. In Pennsylvania only 5.7 per cent of the physicians to whom the new report form was sent three months ago have reported.

In no state of the 44 replying is the physician paid a fee for such reports; 13 states do not believe it ever would be desirable to pay such a fee. No such fee is paid in Pennsylvania.

Reporting by Hospitals

Of those replying to the questionnaire, 13 states and territories have a central tumor registry wherein copies of tumor records and follow-ups are received regularly from hospitals. Of these, 11 are on a voluntary basis, while 2 require such reports; 20 have no such tumor

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registries. Several states were unable to answer this question since local procedures vary considerably.

The amounts and methods of financial reimbursements, if any, for such records vary. Six states indicate no reimbursement; 12 pay hospitals for secretarial or record-copying assistance, using—as noted above—various methods of payment. In 2 states a flat rate has been worked out so that each hospital may be reimbursed two or three times a year on the basis of the number and quality of records sent in. Eight states are in favor of reimbursement even though not able to finance such a project at present.

Sixteen states indicate that copies of hospital tumor records are satisfactory, while 3 are not satisfied with the records. Where this plan is in effect, the approximate percentage of hospitals now sending in copies of records varies from 100 per cent in one small state to 5 per cent in others. In most instances the percentage is not impressive. Pennsylvania compares favorably with other states in this regard in that approximately 30 per cent of hospitals in the Commonwealth are now reporting on a voluntary basis. The real problem in Pennsylvania is the *cost* involved in obtaining such voluntary reports from hospitals. Since the activity was started three years ago, the Division of Cancer Control has been reimbursing many hospitals or paying state field workers for secretarial or clerical assistance in copying such records and sending them to the Division and for a certain amount of office equipment. Eighteen hospitals have transmitted such records voluntarily to the Cancer Division without any reimbursement.

Conclusion

The Division of Cancer Control of the Pennsylvania Department of Health desires to obtain the widest and best possible advice and guidance on the value and methods of morbidity statistics in cancer control. This preliminary factual report, therefore, is presented to the Secretary of Health of the Commonwealth and the Cancer Commission of the State Medical Society for consideration and discussion. This study will be continued and it is hoped that in a subsequent report recommendations may be made which will indicate the best future course to follow in Pennsylvania on methods and use of statistics in cancer control.

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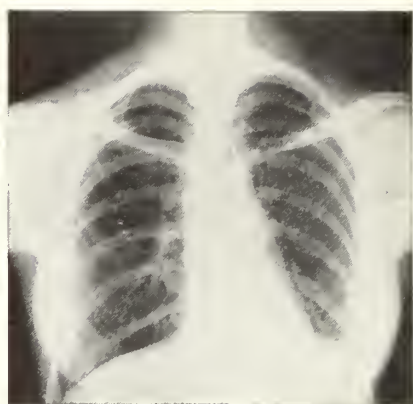
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TO DR. AND MRS. CHARLES S. TURVILLE, of Drexel Hill, a daughter, Martha Nichols Turville, February 6.

Engagements

MISS DORIS J. SADLER to Mr. Milton M. Dougherty, Jr., son of Dr. and Mrs. Milton M. Dougherty, all of Mechanicsburg.

MISS EDYTHE M. PAUL, daughter of Dr. and Mrs. James H. Paul, of Philadelphia, to Mr. Harry F. Purdy, Jr., of Camden, N. J.

MISS ELIZABETH COOK STELLWAGEN, daughter of Mrs. Thomas C. Stellwagen, Jr., of Drexel Hill, and the late Dr. Stellwagen, to Dr. John Douglas McCurtain, of Cape Cod, Mass., a dentist.

MISS RUTH E. WILSON, of Mt. Airy, to Mr. Robert Magaziner, son of William E. Magaziner, M.D., of Philadelphia, and the late Mrs. Magaziner. Mr. Magaziner is studying medicine at Temple University School of Medicine.

MISS DOROTHY M. HITCHON, of Philadelphia, to Robert D. Rector, M.D., of Mechanicsburg. Dr. Rector is at present a lieutenant in the Medical Corps of the United States Naval Reserve, on active duty with the destroyer *USS Compton*, now in the Caribbean.

Marriages

MISS ANNE BLISS, of Brookline, Mass., to Mr. Robert Bower, son of Dr. and Mrs. John O. Bower, of Wyncote, March 4.

MRS. ELIZABETH SIMMS BIDDLE, of Haverford, to Charles A. Behney, M.D., of Bryn Mawr, some time in February, in Mexico.

MISS MARY CYNTHIA COX, of Greensboro, N. C., to Mr. Allen Hoyt Moore, Jr., son of Dr. and Mrs. Allen H. Moore, of Doylestown, March 16.

MISS EMMA G. WEBER, chief nurse of the Tuberculosis Division, Bureau of Communicable Diseases of the Philadelphia Department of Health, to Rufus S. Reeves, M.D., Director of Public Health in Philadelphia, March 4.

Deaths

○ Indicates membership in county medical society, *The Medical Society of the State of Pennsylvania*, and the *American Medical Association*.

○ Eldridge L. Eliason, Philadelphia; University of Pennsylvania School of Medicine, 1905; aged 70; died March 6, 1950, following a short illness. Dr. Eliason was made assistant instructor in surgery at the University of Pennsylvania Medical School in 1907. In 1936 he was appointed John Rhea Barton professor of surgery, and upon his retirement from the faculty in 1945 he was made emeritus professor. He also served on the faculty of the University's Graduate School of

Medicine until his retirement. In addition to his service at University Hospital, he was surgeon for Philadelphia General and Presbyterian Hospitals, and a former member of the surgical staffs of Delaware County and Mt. Sinai Hospitals. During World War I, he served as a lieutenant colonel in the Medical Corps and was chief surgeon of a base hospital. He was a Fellow of the American College of Surgeons, and a member of the American Surgical Association and the International College of Surgeons. He was the author of numerous papers and medical books. A brother and sister are the only survivors.

John C. Gittings, Wynnewood; University of Pennsylvania School of Medicine, 1895; aged 75; died March 8, 1950. He was professor emeritus of pediatrics at the University of Pennsylvania Medical School. In 1930 Dr. Gittings went to Maryland where he was appointed visiting lecturer in pediatrics at the Johns Hopkins University School of Medicine. In 1933 he returned to Penn and was appointed to the William H. Bennett professorship in pediatrics. He was a former president of the American Pediatrics Society. He served on the editorial board of the *American Journal of Diseases of Children* since 1928. He was the author of two books, "Infant Feeding" and "Tuberculosis," and wrote many clinical and scientific articles. During World War I, he served as a lieutenant colonel in the Medical Corps. Surviving are his widow and a daughter.

○ Stephen Mitterling, Philadelphia; Medico-Chirurgical College of Philadelphia, 1911; aged 71; died March 19, 1950. Dr. Mitterling was an instructor at his alma mater until the college closed in 1916. From then until 1928 he was an instructor of anatomy at the School of Medicine of the University of Pennsylvania. In later years he was an instructor in the ear, nose and throat department of the Graduate School of Medicine at the University. For many years he was a member of the staff of Methodist Hospital and the courtesy staff of other hospitals. For the past 15 years he had been physician for the Presbyterian Home for Widows and Single Women. He is survived by his widow and a son, Robert C. Mitterling, M.D., of Springfield.

○ Christian Gruhler, Shenandoah; Medico-Chirurgical College of Philadelphia, 1899; aged 80; died Feb. 27, 1950. He was born in Jaffa, Asia Minor, where his parents were serving as missionaries of the Lutheran Church. Prior to studying medicine, Dr. Gruhler was graduated from the Philadelphia College of Pharmacy and briefly followed that profession. He was an outstanding figure in his community and all his life was active in its affairs. In addition to his work in combating contagious diseases, he was widely known as an obstetrician. In 1940 he was a vice-president of the State Society. Surviving are his widow, one brother, and two sisters.

○ **James H. Burrows**, Williamsport; University of Pennsylvania School of Medicine, 1920; aged 53; died March 6, 1950, at Phoenix, Ariz., where he was visiting friends. Dr. Burrows was a veteran of both World Wars. In World War II he was a flight surgeon in the Navy and served overseas as a senior medical officer. He held the rank of commander. He specialized in eye, ear, nose and throat diseases, but in 1948 he was found to be suffering from a coronary occlusion and gave up his private practice. He served last year as president of the Lycoming County Medical Society. Surviving are his widow, two sons, one daughter, two sisters, and a brother.

○ **Abner H. Bauscher**, Reading; Jefferson Medical College of Philadelphia, 1908; aged 67; died Feb. 24, 1950, after an illness of several months. Dr. Bauscher was a member of the staff of St. Joseph's Hospital for 30 years, and at one time headed the department of gastro-enterology. He was president of the staff in 1938. He was also a past president of the Berks County Medical Society. During World War I, he served on many battle fronts with the 28th Division. He held the rank of lieutenant colonel in the U. S. Army Medical Reserve Corps. Surviving are his widow, a son, his father, and a sister.

○ **David Nathan**, Norristown; McGill University Faculty of Medicine, Montreal, Canada, 1906; aged 72; died Feb. 26, 1950, after a five months' illness. A neurologist and psychiatrist, Dr. Nathan maintained offices in both Norristown and Philadelphia. He was on the staff of the Graduate Hospital, Philadelphia, Pottstown Hospital, and Sacred Heart Hospital. He was a member of the Association for Research in Nervous and Mental Diseases. During World War I, he served in England and Scotland as a captain in the Canadian Army Medical Corps. His widow and a brother survive.

○ **William H. Mease**, Uniontown; University of Pittsburgh School of Medicine, 1937; aged 36; died March 12, 1950, of an intracranial malignancy. Dr. Mease was a Fellow of the American College of Surgeons, a diplomate of the American Board of Obstetrics and Gynecology, and a member of the Pittsburgh Obstetrical and Gynecological Society. During World War II, he was chief of surgery at the 33d Station Hospital in England and was discharged with the rank of major. He is survived by his widow, a son, a daughter, his mother, and a sister.

○ **Stephen S. Watson**, Scranton; Jefferson Medical College of Philadelphia, 1894; aged 82; died Feb. 25, 1950. Dr. Watson, one of the oldest members of the Lackawanna County Medical Society, had been in poor health for several years but continued his office practice. He was chief surgeon at the Taylor Hospital for many years and at his death was chief surgeon emeritus of the hospital. In 1944 he was honored by the members of the surgical and medical staffs of Taylor Hospital upon completion of 50 years of service. Surviving are one son and a sister.

○ **Paul E. Cunningham**, Franklin; University of Pittsburgh School of Medicine, 1910; aged 63; died

Feb. 9, 1950. He had suffered a heart attack several weeks before, from which he had never really recovered. Dr. Cunningham was one of Venango County's best known and most highly esteemed citizens. During his 40 years of service he had an extensive obstetric practice. For a number of years he was coroner of Venango County. Surviving are his widow and a daughter.

○ **H. Cotter Boyle**, Philadelphia; Temple University School of Medicine, 1914; aged 62; died March 20, 1950, after a long illness. He had practiced in Philadelphia more than 30 years. For a time he also was a surgeon on the staffs of Sacred Heart and Allentown General Hospitals in Allentown. He was a captain in the British Army during World War I and was wounded in service. Surviving are his widow, two children, a brother, and a sister.

○ **Walter L. Angle**, East Stroudsburg; Maryland Medical College, Baltimore, 1903; aged 70; died June 10, 1949, of coronary occlusion, approximately seven hours after returning home from the AMA convention in Atlantic City. Dr. Angle gave up general practice in 1930 to specialize in eye, ear, nose and throat diseases after doing graduate work in Europe. He was always active in civic affairs. His widow survives.

○ **Andrew Callahan**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1899; aged 75; died Feb. 17, 1950. He was a specialist in diseases of the chest and was a former assistant professor of medicine at the Graduate School of Medicine of the University of Pennsylvania. Surviving are his widow, a son, Andrew Callahan, 3d, M.D., and two daughters.

○ **Van C. Decker**, Nicholson; Jefferson Medical College of Philadelphia, 1896; aged 81; died Feb. 4, 1950, from a fractured skull due to a fall. He served as a lieutenant colonel in the Medical Reserve Corps in World War I and on the Selective Service board from 1940 to 1945. He is survived by a daughter and a son.

○ **John M. Wenger**, Terre Hill; University of Pennsylvania School of Medicine, 1910; aged 66; died Feb. 25, 1950. He was deputy coroner for 13 years and president of the school board in Terre Hill for the past 30 years. He is survived by his widow, a son, and a daughter, also his father, three sisters, and three brothers.

○ **Charles S. Sentner**, Benton; Jefferson Medical College of Philadelphia, 1929; aged 44; died suddenly March 4, 1950. He was a captain in the Army Medical Corps during World War II. In addition to his parents, Dr. Sentner is survived by his widow, three children, three brothers, and four sisters.

○ **Harvey E. Massy**, Sharon; Ohio State University College of Medicine, Columbus, 1911; aged 64; died March 11, 1950, in St. Petersburg, Fla., where he had gone to recuperate from an operation. Dr. Massy was a veteran of World War I. He is survived by his widow and a daughter.

○ **Justin L. Christian, Sr.**, Harrisburg; College of Physicians and Surgeons, Baltimore, Md., 1890; aged

83; died Feb. 27, 1950. He was a former member of the State Legislature from Sullivan County. Surviving are one son, J. Loomis Christian, M.D., of Harrisburg, and a sister.

○ Andrew W. O'Malley, Clarks Summit; Illinois Medical College, Chicago, 1908; aged 66; died March 11, 1950, after a brief illness. A native of Wilkes-Barre, Dr. O'Malley was clinical director of the Clarks Summit State Hospital. Surviving are his widow, two sons, three daughters, and a sister.

William G. Kinsley, Robeson; Boston University School of Medicine, 1914; aged 57; died Feb. 12, 1950. He was a captain in the Army Medical Corps in World War I. Survivors are his widow, a son, a daughter, his father, and two sisters.

○ Max F. Herrman, Philadelphia; University of Pennsylvania School of Medicine, 1902; aged 68; died Feb. 8, 1950. Surviving are three sisters and a brother, Clinton S. Herrman, M.D., of Philadelphia.

○ H. Ward Fisher, Wilkes-Barre; Hahnemann Medical College and Hospital of Philadelphia, 1911; aged 64; died March 14, 1950, following a heart attack. He was a staff member of the Wyoming Valley Hospital.

○ Charles L. Harsha, Canonsburg; Jefferson Medical College of Philadelphia, 1903; aged 73; died March 20 after a long illness. He is survived by his widow, three sisters, and a brother.

Joseph E. Johnston, Pittsburgh; Cleveland Medical College, Ohio, 1896; aged 85; died March 12, 1950. Surviving are his widow, a son, a brother, and a sister.

Allen G. Gantr, Pittsburgh; University of Pittsburgh School of Medicine, 1901; aged 84; died March 14, 1950, following an illness of two years.

Miscellaneous

THE 144TH ANNUAL MEETING OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK will be held May 8 to 12, 1950, at the Hotel Statler, New York City.

HARRY F. HOFFMAN, M.D., superintendent of the Allentown State Hospital for eight years, has resigned the post effective June 30. He joined the Allentown State Hospital staff as assistant superintendent in 1912.

THE SIXTH ANNUAL CONFERENCE OF THE AMERICAN SOCIETY FOR THE STUDY OF STERILITY will be held at the Sir Francis Drake Hotel, San Francisco, Calif., June 24 and 25, 1950. Further information concerning this meeting may be obtained from the society's office at 20 Magnolia Terracc, Springfield 3, Mass.

THOMAS PARRAN, M.D., dean of the Graduate School of Public Health, University of Pittsburgh, has announced the appointment of Dr. Francis S. Cheever as Professor of Microbiology in the Department of Epidemiology and Microbiology. Dr. Cheever comes to Pittsburgh from Boston where he had been assistant professor of bacteriology and immunology at Harvard Medical School.

THE MIDDLE ATLANTIC HOSPITAL ASSEMBLY'S SECOND ANNUAL CONVENTION will be held in Buffalo, N. Y., May 24, 25, and 26. Convention headquarters will be at the Hotel Statler. The meetings and the exhibits will be held in the Memorial Auditorium; and the hospital equipment and education exhibits will present to the hospital field an impressive display that will make this convention one of the outstanding events of the year.

PRESIDENT HAROLD E. STASSEN of the University of Pennsylvania has announced the appointment of Dr. Peter C. Goldmark, of New York, as visiting professor of medical electronics in the School of Medicine of the University. Establishment of the new faculty chair by the University of Pennsylvania is said to be the first such action ever taken by an institution of learning.

HARRY M. EBERHARD, M.D., of Philadelphia, senior physician at Hahnemann Hospital, was honored by 50 fellow physicians at a dinner in the Union League, February 22, on his retirement as professor and head of the department of gastro-enterology at the hospital and Hahnemann Medical College, a post he held for 40 years.

TWO UNITS IN THE PROPOSED NEW \$6,000,000 LAN-KENAU HOSPITAL in Philadelphia are provided for in a gift of \$300,000 by Mrs. Charles Schmidt, of Philadelphia, in memory of her late husband. The gift covers the cost of the auditorium and health museum in the proposed new hospital to be erected on the Overbrook Golf Course site at City Line and Lancaster Avenue.

COPIES OF THE FIRST ISSUE of the *Journal of the Philadelphia General Hospital*, a quarterly published by the hospital, can be obtained by anyone interested by writing to the hospital. The magazine is edited by Pascal F. Lucchesi, M.D., superintendent and medical director, and a consulting board of editors including William P. Boger, M.D., Jefferson H. Clark, M.D., William E. Ehrlich, M.D., Thomas M. McMillan, M.D., John F. Stouffer, M.D., and Bernard P. Widmann, M.D.



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THE EASTERN SECTION OF THE AMERICAN CONGRESS OF PHYSICAL MEDICINE will hold its spring session in conjunction with the New England Society of Physical Medicine, the Section on Physical Medicine of the Medical Society of the County of Kings, the New Jersey Society of Physical Medicine, the New York Society of Physical Medicine, the Pennsylvania Academy of Physical Medicine, and the Society of Physical Medicine of the District of Columbia on Saturday, April 29, at the George Washington University Hospital, 901 Twenty-third St., N. W., Washington, D. C.

THE PENNSYLVANIA ACADEMY OF GENERAL PRACTICE will hold its 1950 scientific session at the Penn-Harris Hotel, Harrisburg, May 25 and 26. A business meeting will be held Thursday morning, May 25, and the remainder of the two days will be devoted to the presentation of scientific papers. A banquet will be held Thursday evening, and special entertainment will be provided during the entire meeting for the wives of academy members.

THE PRESIDENT AND OFFICERS AND THE MEMBERS OF THE BOARD OF TRUSTEES of the United States Pharmacopeial Convention have invited representatives of The Medical Society of the State of Pennsylvania to attend the ceremonies in connection with the dedication of the Pharmacopeia Building, 46 Park Ave., New York City, on Wednesday, April 12, 1950. The formal dedication ceremony was held in the Hall of the Morgan Memorial Library, Madison Ave. and 36th St., New York City.

JOHN P. HUBBARD, M.D., of Philadelphia, has been appointed associate secretary on the executive staff of the National Board of Medical Examiners, Philadelphia. He assumed his duties on March 1, when he retired from the position of director of the Committee for the Improvement of Child Health of the American Academy of Pediatrics. Dr. Hubbard has also been appointed on a part-time basis, effective April 1, to the position of professor of public health and preventive medicine and head of the department at the University of Pennsylvania School of Medicine.

JAMES J. WALKER, JR., M.D., instructor in surgery and Fellow in the Harrison Department of Surgical Research of the University of Pennsylvania School of Medicine, has been named a scholar in medical science by the John and Mary R. Markle Foundation of New York. A grant of \$25,000 to the medical school of the university accompanies the appointment of Dr. Walker. It will go towards his support as teacher and research worker during the next five years. He is noted for his researches in the therapy of burns and shock.

FREDERICK H. ALLEN, M.D., director of the Child Guidance Clinic in Philadelphia, was given the \$10,000 Philadelphia Award, February 21, in recognition of outstanding service rendered to the city and its people. The award was made at a dinner in the Barclay which was attended by more than 100 persons. Dr. Allen, who is

clinical professor of psychiatry in the University of Pennsylvania's Medical School and its Graduate Medical School, has helped to work out plans for development of child psychiatry services in the Philadelphia public schools. The award was established in 1921 by the late Edward W. Bok.

THE LAENNEC SOCIETY of Philadelphia will give a prize of \$200 for the best paper in the field of thoracic disease submitted by an undergraduate medical student, intern, or resident in Pennsylvania. The work should be original and not a review of literature or of previous contributions. The society does not reserve the right of publication, but requests that the prize-winning paper be presented at one of its regular scientific meetings.

Manuscripts submitted should be double-spaced with wide margins, bibliography, and appropriate illustrations. They should be in the hands of the secretary of the society, Katharine R. Boucot, M.D., 311 South Juniper St., Philadelphia 7, Pa., by Nov. 1, 1950.

CHARLES L. BROWN, M.D., dean of Hahnemann Medical College and Hospital of Philadelphia, recently announced the following faculty appointments: Drs. Charles M. Thompson, professor and head of the Department of Gastro-enterology; J. Stauffer Lehman, professor and head of the Department of Radiology; Charles B. Hollis, professor and head of the Department of Otolaryngology; Joseph E. Inbriglia, professor and head of the Department of Clinical Pathology; Randal A. Boyer, associate professor of radiology; Axel K. Olsen, associate professor of surgery, in charge of the section on neurosurgery; Edward C. H. Schmidt, associate professor of pathology; and Brian A. Cookson, instructor in physiology. Announcement was also made of a \$50,000 contribution by Mr. William Goldman, of the Goldman Theaters, as an addition to the William Goldman Dean's Fund, which is for unrestricted use for any needs of the college.

ESMOND R. LONG, M.D., director of the Henry Phipps Institute for the study, treatment, and prevention of tuberculosis, has been selected by the Philadelphia County Medical Society to receive the 26th annual Strittmatter Award. The presentation was made on April 12 at a joint meeting of the county society and the Laennec Society of Philadelphia, of which Dr. Long is a charter member. This annual award, consisting of a gold medal and scroll, was established in May, 1923, by Dr. I. P. Strittmatter and is given "to any physician making a valuable contribution to the healing art, including remedial measures, surgical, medical or contribution to one of the fundamental sciences of medicine, having a beneficial influence on either surgery or medicine, or for any extraordinary meritorious service redounding to the credit of the medical profession." Last year's recipient was Catharine Macfarlane, M.D., noted cancer specialist.

PHYSICIANS SERVING INDUSTRIES OR PRACTICING in areas where industrial employees form a part of the patient load will be interested in the postgraduate course

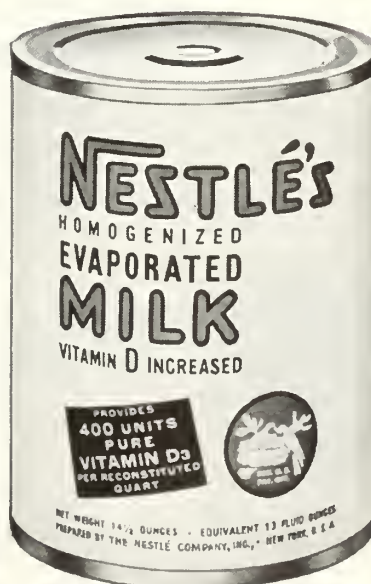
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to be offered in Pittsburgh May 15 to 19. The topic is "Pulmonary Diseases and Their Relation to Employment."

The course is being offered by the American Trudeau Society under the auspices of the University of Pittsburgh's School of Medicine and Graduate School of Public Health and the Industrial Hygiene Foundation of America, Inc.

A participating faculty of 42 members, highly regarded in their respective fields, has been assembled from medical schools and industrial firms in northeastern United States and Canada. During the four-day session they will present an intensive program on the pulmonary diseases which most frequently have bearing on employability. The wide range of sub-topics includes tuberculous and non-tuberculous infections, allergic diseases, pulmonary malignancy, as well as both acute and chronic occupational lung diseases.

The tuition fee for the postgraduate course is \$50. Applications for the course should be made as soon as possible. Physicians may obtain further information and application blanks by writing directly to the American Trudeau Society, 1790 Broadway, New York 19, N. Y.

THE AMERICAN PHYSICIANS ART ASSOCIATION will have its twelfth art exhibition in conjunction with the American Medical Association convention at San Francisco Auditorium, June 26 to 30, 1950.

Any physician who follows the hobby of fine or applied arts can exhibit at this convention by becoming a member of the A.P.A.A. and applying for entry

blanks and shipping labels of the secretary, F. H. Redewill, M.D., 526 Flood Bldg., San Francisco 2, Calif.

More than one hundred trophies will be awarded to advanced physician artists (A) as well as to beginners (B) who have done art work less than two years. The main purpose of the association is to encourage all physicians to take up art in some form as an avocation.

For those physicians who have never done any painting, photography, sculpture, wood or metal craft, etc., they can, without obligation, learn how to become creditable amateurs by writing to the secretary.

The American Physicians Art Association with its 4000 members is recognized as having the finest amateur art shows in the world during the AMA conventions and the association is desirous of having every physician who does art work participate.

APPROVES BLUE SHIELD EXPANSION

The Honorable James F. Malone, State Insurance Commissioner, writes MSAP congratulating them on their widened coverage effective April 1: "For the splendid contribution you are making to the welfare of your more than 600,000 subscribers in the Commonwealth of Pennsylvania. In my humble judgment, what the Medical Service Association of Pennsylvania is doing is the *complete answer* to those in this country who would bring down upon the people *socialized medicine*."

FOURTEENTH ANNUAL POSTGRADUATE INSTITUTE THE PHILADELPHIA COUNTY MEDICAL SOCIETY

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Subjects to be Presented

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Virus Diseases of the Skin	Gastrointestinal Hemorrhage
Antibiotics and Chemotherapy	Obstetrical and Gynecological Problems
Management of Inoperable Malignancies	Geriatrics
Rehabilitation	Fractures and Dislocations
Carcinoma of the Prostate	Arthritis
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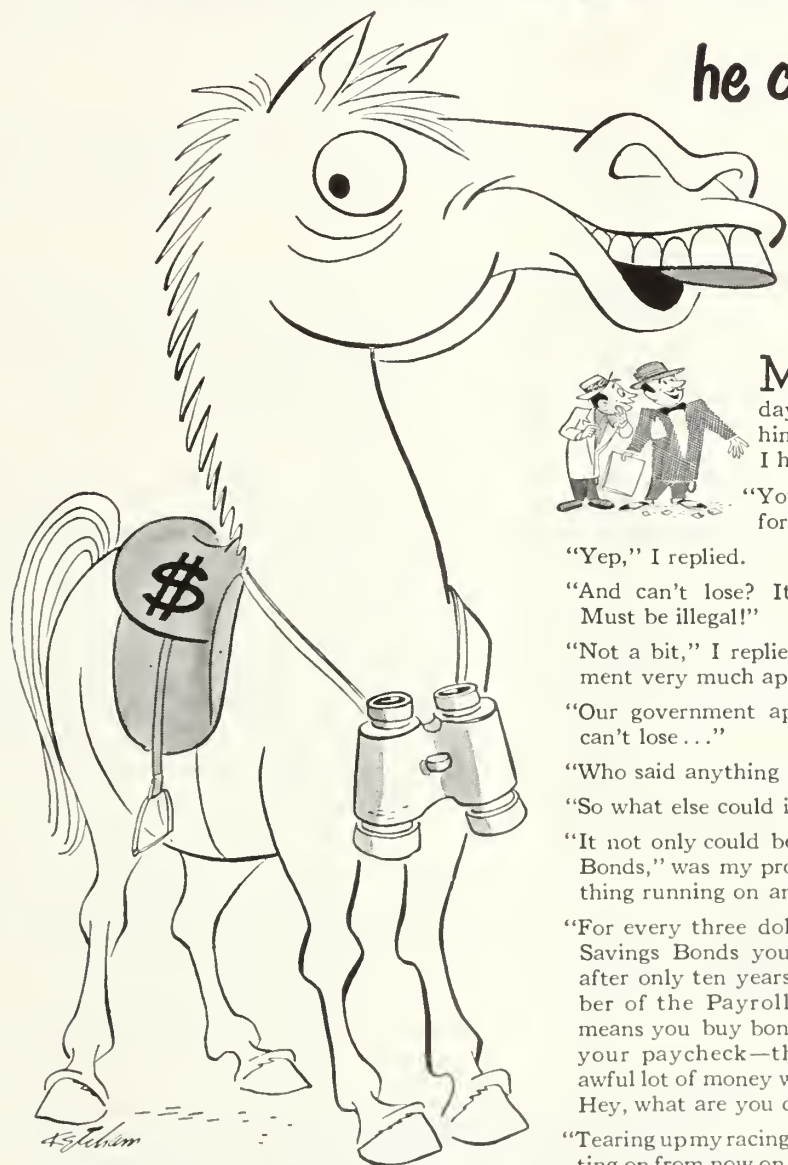
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"There's no such animal," he cried!



MY FRIEND and I were picking the ponies one day when I started telling him about a *sure thing* I heard about.

"You say it pays four bucks for every three?" he asked.

"Yep," I replied.

"And can't lose? It *automatically* wins? Must be illegal!"

"Not a bit," I replied. "In fact, the government very much approves..."

"Our government approves of a horse who can't lose..."

"Who said anything about a horse?" I asked.

"So what else could it be but a horse...?"

"It not only could be—but is—U. S. Savings Bonds," was my prompt reply. "The surest thing running on any track today."

"For every three dollars you invest in U. S. Savings Bonds you get four dollars back after only ten years. And if you're a member of the Payroll Savings Plan—which means you buy bonds *automatically* from your paycheck—that can amount to an awful lot of money when you're not looking. Hey, what are you doing?"

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For Rent.—Doctor's offices for rent because of death. Well established practice. Excellent opportunity. Write MRS. C. W. SCHWALM, Shoemakersville, Pa.

Wanted.—General practitioners for rural practice in Juniata County. Contact ROBERT P. BANKS, M.D., Secretary, Juniata County Medical Society, Mifflintown, Pa.

General Residency.—To start July 1, 1950; salary open: 346 bed general hospital, approved by the American College of Surgeons. Apply to SUPERINTENDENT, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

Wanted.—Otolaryngological resident for Episcopal Hospital, Philadelphia, Pennsylvania, beginning July 1, 1950. For details write Otto C. HIRST, M.D., Episcopal Hospital, Philadelphia 25, Pa.

Wanted.—Physician with Pennsylvania license for full-time institutional work. Excellent professional facilities. Living quarters for family optional. Write Dept. 189, PENNSYLVANIA MEDICAL JOURNAL.

Wanted Immediately.—Two house physicians for 116-bed general hospital. Approved by the American College of Surgeons. Excellent opportunity. Good salary. Apply SUPERINTENDENT, Mercy Hospital, Johnstown, Pa.

Wanted.—Alert, young general practitioner as locum tenens for one year in town of 7000 near Altoona. Include reference letters and photographs in first letter. Will notify prior to May 1, 1950. Write Dept. 185, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Resident house physician, male or female, licensed to practice in Pennsylvania or eligible for reciprocity; 202-bed general hospital. Apply to JANE M. BOYD, ADMINISTRATOR, Butler County Memorial Hospital, Butler, Pa.

Wanted.—Clinical pathologist—part time. We are interested in making contact with certified pathologist to help us on a part-time basis. For further details please communicate with A. C. SEAWELL, Pottstown Hospital, Pottstown, Pa.

House Physician Wanted.—Grand View Hospital, of Sellersville, wishes to employ a house physician. Give references, experience, and salary desired in first communication. Write SUPERINTENDENT, Grand View Hospital, Sellersville, Pa.

Available.—Busy unopposed rural practice drawing from a population of 3000. Hospital facilities. Only investment needed about \$1,000 for drugs and equipment. Home-office combination, \$50 per month. Specializing. Write A. S. RUBENSTEIN, M.D., LeRaysville, Pa.

Assistant Wanted.—General practitioner and roentgenologist needs an assistant due to ill health. Office and location established over fifty years. Ear, nose, and throat man preferred. Excellent X-ray equipment available. Write Dept. 175, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Combination home and office in community of 10,000 people. General practice established 35 years. Located in northeastern Pennsylvania. Chief industries are railroads, manufacturing, and farming. Open-staffed hospital. Retiring. Write DEPT. 187, PENNSYLVANIA MEDICAL JOURNAL.

Residents and Interns Wanted.—Resident physician with Pennsylvania license. Salary \$400 per month with full maintenance. Interns—salary \$200 per month with full maintenance. 191-bed general hospital. Fully approved by A.C.S. Write ADMINISTRATOR, Hahnemann Hospital, Scranton, Pa.

Wanted.—General practitioner for rural section of Huntingdon County. Area includes Marklesburg, Entriken, and James Creek. House available. Community organizations very interested in obtaining physician. Contact either MISS BETTY G. BEANER, Secretary, Lincoln Grange 94, Entriken, Pa., or MRS. FLORA J. GARNER, P. M., James Creek, Pa.

For Sale.—General practice with all supplies and equipment for price of equipment alone: Includes 100 KV, 100 MA X-ray and fluoroscopic unit with all accessories. Office suite of six rooms in central location of small industrial community 30 miles west of Philadelphia. Price, \$5,000. Write Dept. 183, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Fully equipped modern office of recently deceased young physician. Practically new 100 MA. X-ray (G. E.), two Whirlpool Baths, diathermy, laboratory equipment, waiting room and office furniture. Well established practice in thriving mining community. Contact or write MRS. WILBUR J. HAWKINS, JR., P. O. Box 487, Fredericktown, Pa.

For Sale.—General semi-rural practice established 15 years. Modern house and semi-detached office complete with insulation, new oil hot water heating system, x-ray, ultraviolet, drugs, etc. Six miles from new general hospital employing full-time roentgenologist and pathologist. Will introduce. Specializing. Write DEPT. 188, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—A Philadelphia allergist, diplomate in internal medicine, Fellow of American Academy of Allergy, will give short courses in the management and treatment of allergic diseases; preparation of dilutions for testing; interpretation and evaluation of histories and results of testing; pollen and dust extract preparation; also new methods of desensitization for inhalants, pollen and dust. Write DEPT. 186, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Physician for industrial medical work in sales territory, New England to Florida, including examination of employees, co-ordination of work of fee-basis physicians, general assistance with administration of medical division and development of medical policy; some travel including four two-to-four-week trips each year. Must have or be eligible for Pennsylvania license; prefer young man with some experience in private practice. Address inquiries to Mr. H. M. OVERLEY, THE ATLANTIC REFINING Co., P. O. Box 7257, Philadelphia 1, Pa.

ECONOMIC DANGER FROM AGING POPULATION

Greatly increased voting strength of the older population of the United States can lead to ruthless exploitation of youth, an American Medical Association economist warns.

The number of people 65 and over in the nation has quadrupled since 1900, while the general population has doubled, points out Frank G. Dickinson, Ph.D., Chicago, director of the AMA Bureau of Medical Economic Research.

"We face a grave problem of social morality," Dr. Dickinson says. "We who are 50 years of age have the power to make life miserable for the President, the senators, the congressmen, the governors, the legislators.

"They all know that the proportionate voting strength of the older population is increasing. We older people have the voting power to fasten ourselves on the pay checks of youth. The question is how far we want to go in using our power to exploit youth.

"Do we want to have our pay checks clipped for a few years and then retire with the assurance that those at the working ages will provide us with free medical care, free housing, free food, while we spend our income during our retired years as we see fit?

"Youth will find a way to get even with those of us who were born before 1900. This may require only a process of higher prices, higher wages, higher salaries; nowadays higher pensions get into that inflationary spiral and some would add other cradle-to-the-grave schemes, such as compulsory sickness insurance."

The increase in the proportion of the population of the United States 50 years of age and over is largely due to health progress, according to Dr. Dickinson. The increase in life expectancy and decrease in maternal and infant mortality rates are measures of the tremendous medical progress, aided by better food, better housing, and better sanitation, of the past half-century.

"The older half of the people dying in 1900 had lived 30 years or more, while the older half of the people dying in 1949 had lived 66 years or more," Dr. Dickinson says, adding:

"But the greatest event of these five decades is that death comes much later for the average person."

THE WELFARE STATE

The modern idea of a welfare state is a condition in which almost everybody expects to be taken care of, to be made secure. The state is one's guardian. One does not need to worry about the present or the future; the state will look after him and will provide for his needs. Such a state always starts with making provision of a few items for everybody, and ends up with many, or all his requirements. Some nations in Europe at the present time are shining examples of what may occur.

The term "welfare state," as we have known it, represents a condition which we fear—socialism. Americans have always been rugged individualists, have been able and proud to look after themselves. Recently we are hearing a different interpretation of the welfare state. A campaign is just concluded in New York looking to the election of a United States Senator in which the welfare state has been a main issue. One side abhorred the idea as being something foreign to American ideals; the other side has praised the welfare state as being something desirable, something which our people need.

Senator Hubert H. Humphrey, junior senator from Minnesota, in a discussion over the Town Meeting of the Air Tuesday evening, November 1, praised the welfare state as being an attempt to live up to the provisions of our Constitution, which says a function of government is "to provide for the general welfare." Others in the Administration—Ewing, Truman, Pepper—have praised the welfare state as the Washington bureaucrats see it. Is this a movement stimulated by politicians and would-be office holders to befuddle the minds of our people so that in accepting the provisions of modern socialism, which they are teaching, it would seem that the purposes of our Constitution are being fulfilled?*

The proposed welfare state, if carried to a logical conclusion, would give control of our very lives and existence to office holders and bureaucrats. Socialized medicine is just one feature of this program. We are vitally interested in that, but we are just as profoundly interested in the whole picture.—*Journal of the Michigan State Medical Society.*

* Senator Humphrey's subsequent statements regarding voluntary insurance belie his complete belief in the welfare state.



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The average sized booth will have a back wall of ten feet and two side walls of eight feet each. However, additional back wall space is available if needed.

The Medical Society of the State of Pennsylvania will provide without cost to the exhibitor the following: exhibit space, solid paneled booth which permits tacking of material, shelves, booth sign, electrical outlets, and straight chairs. All other costs are to be borne by the exhibitor including any view boxes needed.

BOOK REVIEWS

Gynecological Histology. By Josephine Barnes, M.A., D.M. (Oxford), M.R.C.P. (London), F.R.C.S. (England), M.R.C.O.G.; Assistant, Obstetric Unit, University College Hospital, London; Assistant Obstetrician and Gynecologist, Elizabeth Garrett Anderson Hospital; Surgeon, Marie Curie Hospital; Membre correspondant, Societe Francaise de gynecologie. With 162 illustrations. New York: Grune & Stratton, 1949. Price, \$6.50.

This book consists primarily of 162 illustrations of normal and abnormal gynecologic histology. Of these, all are photomicrographs except one schematic drawing. Supplementing these pictures is a brief text that discusses the various portions of the internal and external female genitalia. Dr. Barnes states in her preface that she has designed this book as an aid to medical students; as such it can be of value. The pathologist and gynecologist, however, will find that it lacks adequate elaboration.

X-ray Treatment. Its Origin, Birth, and Early History. By Emil H. Grubbe, B.S., M.D., F.A.C.P., Charter Member and Emeritus Member of the Radiological Society of North America; Charter Member of the American Roentgen Ray Society; Diplomate of the American Board of Radiology; Associate Fellow of the American Medical Association; Emeritus Member of the Illinois State Medical Society, and a Member of the Chicago Medical Society. St. Paul and Minneapolis: The Bruce Publishing Company, 1949.

This is a delightful little book dealing with, as the title states, the origin and early history of roentgen therapy. The author was an active participant in vacuum tube research just prior to Roentgen's discovery and thus is well qualified to give an accurate account of those momentous days. The volume starts off with a description of these early workers as well as a fine description of the actual discovery of x-rays by Roentgen.

In subsequent chapters the author traces the development of roentgen therapy from its inception to its present status. The origin is rather completely described since it was Dr. Grubbe himself who founded the science of roentgen therapy. It is interesting to note that the first treatment was given only a few weeks following the date of the discovery of x-rays. There are numerous drawings and photographs of the early therapy machines. The progress of x-ray therapy is given in

chronologic order and makes one of the most interesting chapters in the book. Many excerpts from the early scientific publications are included in this section.

During the investigations of the author, he happened to be the first victim of radiodermatitis. Dr. Grubbe gives a vivid description of this lesion and traces its development into the crippling end results. He cites the various forms of therapy he received and gives advice as to how these lesions are best handled. This description serves as striking evidence for young people working in this field to observe proper precautions.

This book should interest all members of this field as well as the whole medical profession. In reading it, one is deeply impressed by the sacrifices made by the pioneers of roentgenology and becomes more appreciative of their efforts. This book is highly recommended to all people dealing with the use of x-rays in the treatment of disease.

Normal Values in Clinical Medicine. By F. William Sunderman, M.D., Ph.D., Professor of Experimental Medicine and Clinical Pathology, University of Texas Postgraduate School of Medicine; Chief of the Department of Clinical Pathology and Director of Clinical Research, Anderson Hospital for Cancer Research, Houston, Texas; and Frederick Boerner, V.M.D., Late Associate Professor of Clinical Bacteriology, Graduate School of Medicine, University of Pennsylvania; Assistant Professor of Bacteriology at the School of Medicine, University of Pennsylvania; Bacteriologist at Graduate Hospital, Philadelphia; Advanced Bacteriologist, Pennsylvania Department of Health. 845 pages with 237 figures and 413 tables. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$14.00.

To establish the abnormal finding, one must first know the limits of normality. The examining physician is at a loss to evaluate his findings if he does not know where normality ends and abnormality begins. With this idea in mind, this book was conceived by its authors. They realized that workers in the field of medicine and its allied sciences needed a comprehensive source of reference to determine normal values and characteristics. In their search for facts, the authors discovered sometimes that there is no real "norm" and that they would have to be content with averages only. These averages and true normal values were chosen arbitrarily in some instances, and the reader is reminded

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constantly that he must interpret all findings in the light of his own experience.

The reviewer never ceased to marvel at the magnitude of this book. The range of subjects leaves little if anything to be desired, at least insofar as the clinician is concerned. Beginning with the first chapter there is a constant galaxy of facts and figures to satisfy the needs of specialist and general practitioner alike. Normal values in cardiology, hematology, gastroenterology, neurology, obstetrics and gynecology, urology, orthopedics, and metabolism are only part of the contents. There are chapters on the eye, nose and ear, endocrines, respiratory tract, skin, teeth and saliva, and anatomical normals. The concluding chapter deals with statistical methods, food values, drugs, isotopes, and life and actuarial tables. A bibliography is appended to each chapter and an excellent index is present. The reviewer recommends this book to all.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Angina Pectoris and Myocardial Infarction. With special reference to the autonomic nervous system. By Heymen R. Miller, M.D., formerly Principal Physician and Chief, Signal Corps Climatic Research; Attending Physician, Sydenham Hospital; Assistant Professor of Medicine, New York Postgraduate Medical School and Hospital; Associate Attending Physician, Montefiore Hospital. New York: Grune & Stratton, 1950. Price, \$8.75.

Quinidine in Disorders of the Heart. By Harry Gold, M.D., Professor of Clinical Pharmacology at Cornell University Medical College, Attending-in-charge of the Cardiovascular Research Unit at the Beth Israel Hospital, Attending Cardiologist at the Hospital for Joint Diseases, Managing Editor of the *Cornell Conferences on Therapy*. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1950. Price, \$2.00.

Brucellosis (Undulant Fever). Clinical and Subclinical. By Harold J. Harris, M.D., F.A.C.P., with the assistance of Blanche L. Stevenson, R.N. Foreword by Walter M. Simpson, M.S., M.D., F.A.C.P. 111 illustrations, 12 in full color. Second edition, revised and enlarged. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1950. Price, \$10.00.

Brain and Behaviour. Induction as a Fundamental Mechanism of Neuropsychic Activity. An experimental and clinical study with consideration of educational, mental-hygienic, and general sociologic implications. By N. E. Ischlonsky, M.D., New York. With 46 illustrations. St. Louis: The C. V. Mosby Company, 1949. Price, \$7.00.

Physiology of the Eye. Volume One, Optics. By Arthur Linksz, M.D., F.A.C.S., Manhattan Eye, Ear and Throat Hospital, University Hospital, and New York University College of Medicine. Foreword by Walter B. Lancaster, M.D. New York: Grune & Stratton, 1950. Price, \$7.50.

Primer of Allergy. A guidebook for those who must find their way through the mazes of this strange and tantalizing state. By Warren T. Vaughan, M.S., M.D., Richmond, Va. With illustrations by John P. Tillery. Third edition. Revised by J. Harvey Black, M.D., Dallas, Tex. St. Louis: The C. V. Mosby Company, 1950. Price, \$3.50.

The Salt-Free Diet Cook Book. By Emil G. Conason, M.D., and Ella Metz. New York: Lear Publishers, 1949. Price, \$3.00.

Diseases of the Foot. By Emil D. W. Hauser, M.S., M.D., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School; Attending Orthopedic Surgeon, Passavant Memorial Hospital, Chicago. Second edition, illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$7.00.

Visual Development. Volume I. By J. H. Prince, F.R.M.S., F.Z.S., F.B.O.A., F.S.M.C., Late Regional Association Lecturer in Comparative Ocular Anatomy and Ocular Evolution. With a foreword by Professor H. Hartridge, M.A., M.D., Sc.D., M.R.C.P., F.R.S., Professor of Physiology, University of London at St. Bartholomew's Medical College; Director, Vision Research Unit, Medical Research Council, etc. Baltimore: The Williams & Wilkins Company, 1949. Price, \$9.50.

Tuberculosis. A Global Study in Social Pathology. By John B. McDougall, C.B.E., M.D., F.R.C.P. (Edin.), F.R.F.P.S. (Glas.), F.R.S.E. (Section of Tuberculosis, World Health Organization); Honorary Medical Adviser to the British Legion Village, Preston Hall, Kent, England. Formerly Medical Superintendent, Crossley Sanatorium, Delamere Forest, Cheshire, and Woolley Sanatorium, Hexham, Northumberland; Director, Preston Hall Village Settlement, Maidstone, Kent; Nayland Sanatorium, Colchester and Douglas House, Bournemouth. From 1944 to 1947, adviser in tuberculosis to UNRRA in Greece. Baltimore: The Williams & Wilkins Company, 1949. Price, \$6.00.

Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D., Professor of Pediatrics, Temple University School of Medicine; Medical Director of St. Christopher's Hospital for Children. With the collaboration of 63 contributors. Fifth edition with 426 illustrations, 19 in color. Philadelphia: W. B. Saunders Company, 1950. Price, \$12.50.

Medical Management of Gastro-intestinal Disorders. By Garnett Cheney, M.D., Clinical Professor of Medicine, Stanford University Medical School, Chicago: The Year Book Publishers, Inc., 1950. Price, \$6.75.

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1. Beckman, H.: *Treatment in General Practice*. Philadelphia, Saunders, 5th ed., 1946, 704-705.

2. Beckman, H.: *Treatment in General Practice*. Philadelphia, Saunders, 6th ed., 1948, 744.

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An Editorial

Rehabilitation

Donald A. Covalt

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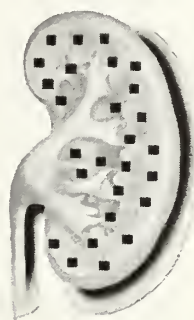
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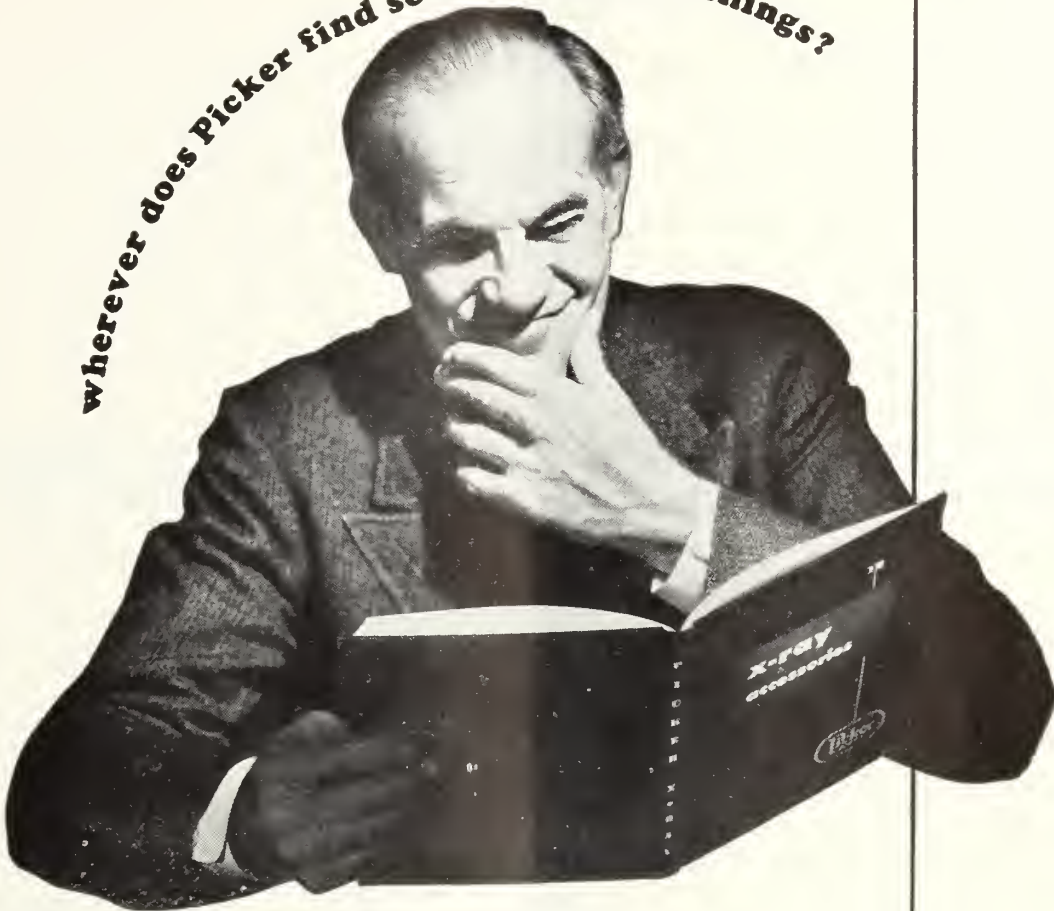
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LETTERS

Keystones Eight Inspire Debate

GENTLEMEN:

A "Brief for Action" is Publication No. 1, dated February, 1950, issued by the League of Women Voters of Pennsylvania.

It is typical of the propaganda put forth by a number of eager, intelligent groups too intent upon following the bellwether into distance-enchanted fields to recall that there are two sides to every question and more than one way to kill the cat.

This pamphlet, by innuendo, would create the impression that the State Health Department is without qualified personnel, that serious communicable diseases are merely "reported" to Harrisburg, that its public health nurses are untrained, that immunization is neglected, et cetera, et cetera, ad nauseam, including the recklessly used and *never supported* statement that Pennsylvania is forty-second among the states in public health endeavor.

It leaves the impression that everything is wrong in Pennsylvania's public health administrative setup and that nothing will do but to plow it under and begin again.

It is particularly lamentable that the leadership in this destructive attitude has come from the State Medical Society's Commission on Public Health and Preventive Medicine, fortified by the action of the House of Delegates at Pittsburgh in 1949. The House there endorsed Keystone No. 6 of the eight "Keystones of Public Health for Pennsylvania" (Survey Report) and gave modified approval to Keystone No. 4.

That leadership and assistance in the interpreting and effecting of the recommendations found in the report of the Administrative Public Health Survey of the State should have come from the medical profession was entirely proper, was anticipated, and would have been welcomed by the Secretary of Health and his whole staff. No such approach seems to have been sincerely made. To the contrary, the road taken was toward non-professional volunteer agencies and the result an unholy alliance whose creed seems to be the unquestioning acceptance of all the recommendations made by the Survey Report and whose sole objective is the exertion of pressure upon the officers of the State Government, from the Governor down, including candidates for the Legislature, for enactment of statutes necessary to bring about the changes thought to be so essential.

Undeniably and equally lamentable, this course has not been and cannot be conducive to the cordial interdependence the medical profession of the State and the State Health Department have heretofore enjoyed and without which the best public health work is impossible. More important than at any time in the past is mutual confidence essential to resist Federal encroachment on the one hand and on the other the pushing of the barriers limiting public health work farther and farther into the realm of clinical medicine and to meet unitedly legislative efforts in our own state not thought in the

best interests of the public from the medical care standpoint.

Much can be said for Pennsylvania's "centralized" administration of public health affairs; of the resulting complete coverage of the State in contrast to glaring gaps where dependence is placed upon *local* county health units; of the complete dependence by practically every state health department in the Union outside of Pennsylvania upon forthcoming (?) Federal grants of money to vitalize hopes for progress in creating these units; of the *new taxes* at the county level, the continuance of high taxes and dangerous deficit spending at the Federal level to make (?) these units possible and of the increased weight of the Federal hand in state affairs these grants will entail; of the mockery of the promise of home rule ("control by the people of their own health services")* under the circumstances.

But our immediate concern is not with all this. Permit us to doubt that the House of Delegates has had opportunity to study carefully all the implications attendant upon its endorsement of Keystone No. 6. Permit us to question whether it was *fully and intelligently advised* with respect to it and to inquire of the Commission on Public Health and Preventive Medicine whether it might not be well to pause and take a look around; to consider whether headlong rush is the best way to engineer a complicated technical job.

It did not require a survey to acquaint the Department of Health with its shortcomings. All of the major ones have been known for some time. They can't be cured at once nor by legislation. In fact, no legislation is needed unless it is desired to shove Pennsylvania into the common "pattern." A pattern is leveling. Individuality is more and more desirable when the trend is to pull the best down to the average—or less.

J. MOORE CAMPBELL, M.D., *Deputy Secretary,*
Pennsylvania Department of Health.

EDITOR'S NOTE: In the published minutes of the 1949 House of Delegates the following appears with its paragraphs numbered 1 and 2 embodying Keystones No. 6 and No. 4 as discussed above:

DR. GEORGE S. KLUMP, vice-chairman, Board of Trustees: The second recommendation deals with the public health survey which was requested at a previous session of this House of Delegates, following which the Secretary of Health and the Governor complied with said request.

The Board of Trustees believes that proper understanding of the survey completed in 1948 by the American Public Health Association and released late in April of this year will of necessity require continued study and consideration by the officers and members of this society. The several chapters of the survey and the recommendations will require the advice of not only

* Page 3, Keystones of Public Health for Pennsylvania. Page 2 contains the eight keystones.

"In addition to the relief of hot flashes and other undesirable symptoms (of the climacteric), a feeling of well-being or tonic effect was frequently noted" after administration of "Premarin."

Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being"

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Pierloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.



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the Commission on Preventive Medicine and Public Health but of the various interested standing committees and several disease control committees.

The Board realizes that there has been insufficient time to develop a program to implement the several desirable recommendations of the survey. However, it believes that the 1949 House of Delegates recognizes its responsibility to the citizens of the Commonwealth and will want to take some positive action in this regard. It respectfully recommends to the House of Delegates that the following two major recommendations of the survey be endorsed. Both have been affirmed in principle by this House at previous sessions, and the second is represented in the AMA twelve-point program.

1. A system applied to *all* public health personnel which will include the best modern practices in recruitment, methods of selection, permanence of employment, equality and adequacy of pay, impartial treatment, and provisions for economic security upon retirement.

2. The establishment of local health units in counties, cities, or other municipalities or in combinations thereof.

The Reference Committee on Reports of Standing Committees, after studying this report, recommended its adoption by the House of Delegates and the House unanimously approved the recommendation.

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Student nurses, Polyclinic Hospital, Harrisburg
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(Continued on page 464.)

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Buhl Hospital School of Nursing, Sharon
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Woman's Auxiliary to Greene County Medical Society
New Bloomfield High School

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Senior Class and Nursing Club, North Wales High School

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Glenwood School, Harrisburg
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REHABILITATION

DONALD A. COVALT, M.D.

New York, N. Y.



SOME 23,000,000 persons in these United States are handicapped to some extent by disease, accidents, maladjustment, or war. We all know that more than one-third of all the draftees passing through the induction centers in the last war had to be rejected as unfit. There are more than 7,000,000 persons in the United States disabled by diseases of the heart and arteries, 6,850,000 from rheumatism and arthritis, and 2,600,000 from orthopedic conditions. In a recent survey published by the National Safety Council in Chicago it was found that the casualties in industry for one year (1947) showed that there were 2,050,000 persons temporarily disabled and 91,000 persons permanently disabled from accidents or occupational disease and that one in every thirty workers suffered a disabling injury.

Along with these figures we must face the fact that the United States has an increasingly aging population. Two thousand years ago the average length of life was 25 years. At the turn of the century, life expectancy was 47 years. Today it is 66 years at the time of birth.

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 27, 1949.

From the New York University Institute of Physical Medicine and Rehabilitation.

Much of this has been accomplished by great strides in preventive medicine, improved methods of diagnosis, tremendous strides made in providing new drugs, and the advances in surgical techniques. Even with these new drugs and new methods, it is our belief that not enough has been accomplished to solve the problem of the persons disabled from chronic disease, accident, and injury. A comprehensive medical and surgical program must include a realistic physical medicine and rehabilitation program if every patient is to receive the opportunity of becoming socially, physically, and economically independent.

During the past three years at Bellevue Hospital and the past year and a half at the Institute of Physical Medicine and Rehabilitation of New York University-Bellevue Medical Center, we have tried to work out what we believe is a realistic yet complete rehabilitation program. We knew that there were tremendous numbers of handicapped persons in the United States in need of such help, but we have been amazed at the number of industrially injured who have been referred to the Institute from industry itself and from insurance companies.

I thought today that I would like to talk to you a little about *how* the Institute of Rehabilitation operates. At the onset it was decided that every facility would be made available to the patient in order to attack all of his problems. Many a disabled person has been prevented from re-

turning to the fullest extent of his rehabilitation because all of the services necessary for his recovery were not available. Dr. Howard A. Rusk* has established the basic philosophy that every facet of a patient's problem must be considered and adequately treated.

A plan was devised to bring into the Institute all of the consultants necessary for any condition that might present itself. To this end, we have consultants in surgery, neurology, an orthopedic surgeon, a urologist, an internist, and a specialist in peripheral vascular diseases. In addition, it was found necessary to put on the staff a full-time psychiatrist and two psychiatric social workers. The full-time staff includes a doctor of physical medicine (a physiatrist), physical therapists, occupational therapists, a vocational counseling department, the prosthetic service, and a speech therapist. We have found that a well-rounded staff facilitates the handling of any problem, and to me it is one of the keynotes to what successes the Institute has had. I might illustrate this briefly by one case.

A man sustained a severe fracture of the humerus. He had been operated upon three times and had an impingement of the nerve resulting in a restriction of range of motion at the elbow and wrist joints and of the fingers. He was sent to us by a doctor whose nurse had been seeing this patient three times a week for the past three years to give him heat and massage. At the end of the three years this patient was sent to us. He was given a careful physical examination for range of motion, muscle tests, and an activities-of-daily-living test as related to his injured arm. He was brought before the evaluation clinic where the entire staff studied his problems. He was seen by the psychologist and was then started on a full day's program. He was given heat and massage by a physical therapist every day, but also at ten o'clock he went to the occupational therapy department for work similar to the work that he was doing on his job when he was injured. Here he concentrated on flexion and extension activities for the fingers and increasing the range of motion of the elbow and wrist. At eleven o'clock he went to one of the functional training rooms where he worked on a pulley to increase the range of motion of the affected joints. In the afternoon, an exercise program was prescribed from two to four o'clock. It was interesting to watch how the range of motion and strength returned. At the end of thirty two full days of treatment, this patient came to my office and said, "Doctor, I might as well go back to work." He showed me that he had practically complete range of motion of the wrist and elbow and that muscle power was almost fully restored. The patient reiterated, "I might just as well go back to work because I am working just as hard here as I would be if I were back on the job and there I get paid for it!"

* RUSK, HOWARD A.: Rehabilitation Its Application to Compensation Medicine. Reprinted from Vol. 1, No. 8, *Compensation Medicine*, December, 1948.

I wish that all of our cases would end so happily but, of course, we have our failures too. However, we have found that our basic plan of a well-rounded program utilizing the entire day has returned many patients to their jobs who were formerly considered hopeless.

Patients who are admitted to the Institute must have a medical abstract from their physician. It has been most interesting to us to see the type of patient referred to the Institute. As an example, a few months ago one of the representatives of an insurance company went on vacation. When she left she had carefully cleaned her desk, and at the end of two weeks, when she returned, she found her desk piled high with medical abstracts. She asked, "What are these?" and was astonished to hear the reply, "While you were gone I had some of the men survey all of our cases. Every file that was over two inches thick is to be referred to the Institute of Physical Medicine!" I know that all of you who have had experience with long-term cases with case files inches thick will realize the problems that exist in such cases. This is *not* a good criterion for patients suitable for rehabilitation!

At the Institute, only those cases are admitted whose abstracts after review have shown that the patient will be benefited by rehabilitation procedures. Every patient is given a careful examination including a range-of-motion muscle test and a test of activities inherent in daily living. The latter test includes those simple things which you and I do without thinking, such as moving from place to place in bed and having the ability to sit erect in bed, to get from the bed to the wheel chair and from the wheel chair to the toilet, to dress and undress, including tying the tie and shoe laces. This test also includes hand activities such as the ability to cut meat and to feed one's self, wheel chair activities, and finally ambulation and elevation activities. We find that the activities-of-daily-living testing can be done by a physical therapist, nurse, or attendant in the home. Such a series of examinations may take from three to five days, and at the end of that time the patient is presented to the evaluation clinic. At that time he is admitted to the Institute either as an inpatient or an outpatient. Patients not feasible for rehabilitation are screened at this time. For those who are suitable for rehabilitation, a program is worked out which will contain a full day's treatment from 9 a.m. to 4 p.m. five days a week.

The prosthetic service is an integral part of the

Institute's service. It is strictly a consultant service. We do not manufacture limbs but rather examine the patient and recommend the proper type of limb for each individual patient. We prefer to see these patients as soon as possible after surgery. After examination, the necessary physical therapy is started immediately to prepare the stump for a prosthetic device. We find that many of our above-the-knee amputees come to the Institute with flexion deformities. Many of these patients have been lying on their backs with a pillow under the stump and we find that two weeks of such a position is enough to give a patient a flexion deformity of the thigh on the hip. It may take weeks and even months to regain normal range of motion of the stump. I would like to suggest that, where possible, one should try to keep the leg in extension if the patient must be kept flat on his back. If necessary to elevate the stump, the patient may be placed on his stomach with pillows under the stump in hyperextension. This will prevent the flexion deformity so common in above-the-knee amputees. As soon as the patient is fitted with the prosthetic device, he is given training to enable him to use his artificial limb.

In the case of an upper extremity amputee, the activities panel board is utilized for practice. This includes the turning of faucets, light switches, door handles—all of the things the patient will encounter in his daily activities and in his work. If it is necessary, the patient is put into simulated surroundings of his job. The occupational therapy department tries to develop the job situation as the patient will find it when he returns to work. We have found that such therapy decreases the amount of time necessary from the time of amputation to the return to the job.

I would like to mention briefly the patient who must be restricted in movement because of fractures of the long bones and the injury of ligaments and capsules that result from sprains. We have found that graduated exercises to the well parts of the body increase the circulation. Research work done on conscientious objectors during the war showed that even a man without an injury would experience a general body debilitation and weakness of muscles if kept on an inactive bed status. In our experience with the Army Air Forces program during the war, we found that patients with fractures of the lower extremities could return to duty faster if they were given systematic and routine exercises of the arms

and of the unaffected leg. With such a program, loss of time from the job was reduced to half the previous time.

I think that one of the most recent advances to come out of the war has been the utilization of preoperative and postoperative exercises in the tuberculous and non-tuberculous thoracoplasty patient. This treatment was developed in England and was brought to this country after the war. Our Veterans Administration hospitals have found that intensive physical therapy for this type of case is most effective. They have demonstrated that instruction before surgery and intensive postoperative exercises are a means of preventing the scoliosis so commonly seen in this type of surgery.

We have had rather extensive experience at the Institute with patients with hemiplegia and quadriplegia. At the present time we are undertaking a research project to develop a program for rehabilitation of the neurologic patient. Altogether, in the past two years, we have had more than one hundred patients with hemiplegia go through the Institute. In those cases of cerebral trauma in which the speech has been affected, I would like to suggest that speech therapy be instituted as soon as possible, for there is nothing so frustrating to a patient who has all of his intelligence but is unable to express himself. A speech therapist or speech pathologist should be utilized as soon as the patient is out of danger. If such a therapist is not available, a high school teacher of speech may be used. In cases of aphasia due to hemorrhage, speech therapy is instituted on an average of four weeks following the accident.

In the case of patients with long-standing neurologic disabilities, it is necessary to check carefully for muscular atrophy. Many of these patients who have been quiescent for months or years in bed are found to have actual nerve and muscle power that can be developed with proper re-education.

In summary, I should like to point out the necessity of treating not the injury alone but of treating the whole man. If we are to enable a patient to come back to the fullest peak of rehabilitation, capable of self-care and back to economic usefulness, we must treat the man as well as the injury. Every facet of his problem, whether it be psychologic, physiologic, sociologic, or economic, must be given adequate attention, and we believe that such treatment must be under the direction of a physician.

Diphtheria Immunity in School Children

(Don't Neglect the Schick Test)

SARAH M. HINDMAN, M.D., and PAUL B. KREITZ, M.D.

Bethlehem, Pa.

IN MARCH and April of 1949 a sporadic epidemic of diphtheria occurred in Bethlehem and its vicinity. There were eight cases, all of which were hospitalized. The throat cultures were positive for *Corynebacterium diphtheriae*. Two of the patients had laryngeal involvement and subsequently died. Of the six with faucial involvement, all recovered with no residual paralyses or apparent cardiac damage. All cases had the typical membrane. Cultures from four of the patients showed marked virulence upon guinea pig inoculation. Cultures from the other four patients grew sparsely upon Loeffler's media and the diphtheria organisms were outgrown by other organisms. The few bacilli present stained characteristically for diphtheria, but their virulence could not be determined.

Case Report

In May, 1949, a 9-year-old boy was admitted to the hospital for diagnosis. Early in March, 1949, this boy had a severe throat infection that was treated with injections of penicillin in oil (300,000 units daily) for three days. On the fourth day of illness he was given diphtheria antitoxin, and throat cultures were sent to the hospital laboratory. The organisms were identified as diphtheroids. These were non-virulent upon guinea pig inoculation. About three weeks after the beginning of the illness, paralysis of the soft palate was noted. The boy continued to lose weight and a staggering gait developed.

Upon admission to the hospital the patient was emaciated but did not appear ill. His blood count was within the limits of normal and his urine was negative. Examination of the eyes showed normal extra-ocular movements. He had peripheral double vision. The pupils were bilaterally equal, reacted to light but not to accommodation. There was a bilateral optic nerve neuritis, most marked on the right. The neuritis was moderate and apparently subsiding. There was a paralysis of the soft palate. The biceps, triceps, knee jerks, and Achilles reflexes were lost. There was weakness and moderate atrophy of the muscles of the extremities most marked on the right side. The cremasteric and abdominal reflexes were present and normal. There was

no Babinski or clonus. The boy walked with an unsteady and staggering gait. The spinal fluid was clear and not under increased pressure. There were seven cells—four red blood cells and three lymphocytes. The spinal fluid protein was 200 milligrams. No organisms were found on smear and culture. Our diagnosis was multiple postdiphtheritic paralyses.

There was no improvement during the short stay in the hospital. Physical therapy was recommended and the child was discharged. He improved steadily and at the end of six months all of the paralyses had disappeared and the absent reflexes and knee jerks had become normal. His general health had improved. It is interesting to note that, in comparison to the extensive damage to the neuromuscular system, the heart showed no apparent damage. The rate, rhythm, and sounds were within the limits of normal. There was no cardiac enlargement.

This case made a total of nine cases of diphtheria. We are at a loss to correlate the extensive residual paralysis with the apparent low virulence of the organisms isolated in our laboratory. Probably the throat infection was a mixed infection and the early use of penicillin might have so modified the host that the virulence of the diphtheria organisms was lowered. Napier¹ believes that in mixed infections the use of penicillin with antitoxin is of particular benefit.

In the spring of 1945 it was believed by the four pediatricians in Bethlehem that immunization against diphtheria was not being sufficiently stressed, and that far too few children were protected. Since the larger medical group disagreed, a survey was undertaken among the school children. Five schools were selected so that a cross-section of children could be obtained. Schick tests were offered upon a voluntary basis, and 958 school children, ranging from 6 to 18 years, were Schick-tested. Control tests were done on all children. The highest percentage of positive Schick reactors occurred at the age of 6 years, and the lowest percentage at 14 years. The mean

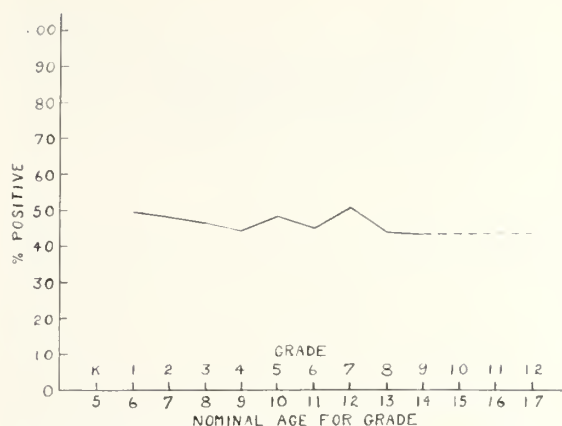


Fig. 1. Schick test survey of Rosemont, Higbee, Calypso, Lindbergh, and Edgeboro Schools in January, 1945.

average of positive Schick reactors was 46.7 per cent. The graph line, however, was fairly straight (Fig. 1).

In the spring of 1948 a second survey was undertaken. Three schools were selected and 746 children between the ages of 5 and 13 years were Schick-tested. Control tests were also done on these children. The results were even more startling than those of the 1945 survey (Fig. 2). At the age of 5 years, 37.9 per cent were positive Schick reactors. The gradient ascended in a reasonably straight line and at the ages of from 11 to 13 years the percentage of positive Schick reactors was 69.4 per cent. In the two surveys there was no appreciable difference in the sexes (see Fig. 2).

Discussion

According to Eichelberger,² in a recent survey among the high school students in York, Pa., "an average of 20 per cent were Schick-positive among 1250 junior high school students and an average of 18 per cent of 1119 senior high school pupils." All of these students had presumably been previously immunized. This means that approximately one-fifth of previously immunized children lose their immunity by the time they reach high school age.

In a survey reported by Schulze³ among troops in Europe during the winter of 1946-1947, it was found that in the 18 to 19-year-old group, 26.7 per cent were Schick-positive or combined reactors, whereas in the 30 to 34-year-old group the percentage was 32.8 per cent. In persons over 34 years of age the percentage was still higher, namely, 35.7 per cent.

Owen,⁴ in a Schick test survey among school children in Philadelphia, Pa., found that 16 per cent of 5661 pupils were Schick-positive. Twelve

per cent of the pupils immunized had positive Schick tests after the first three years. This percentage rose to 39.1 per cent after the twelfth year. A significant feature of this survey was the indication that immunity is lost in increasing ratio as the years go by.

Frazier⁵ states that within three to five years after immunization 10 to 30 per cent of children immunized will have become Schick-positive.

Cohen⁶ and his associates maintain that 40 to 50 per cent of the adult population in New York City and other sections of the country are Schick-positive and lacking an adequate amount of circulating antitoxin.

In 1945 there were 18,669 cases of diphtheria in the United States, 441 of which were in Pennsylvania. In 1946 there were 16,193 cases, 754 of which were in Pennsylvania.

On the basis of these figures it is obvious that either immunizations are not being properly carried out or that the methods and materials are not adequate. The marked decrease in diphtheria is proof that a population can be protected and that the materials used for immunization are satisfactory. Those children having a negative Schick test possess at least one-thirtieth of a unit of circulating antitoxin per cubic centimeter of blood serum. This is sufficient to protect them from diphtheria of moderate virulence. It, however, must be borne in mind that virulent diphtheria bacilli are always present in a community, and that those persons not immunized and those receiving insufficient toxoid will perpetuate the disease. If 100 per cent protection is to be pro-

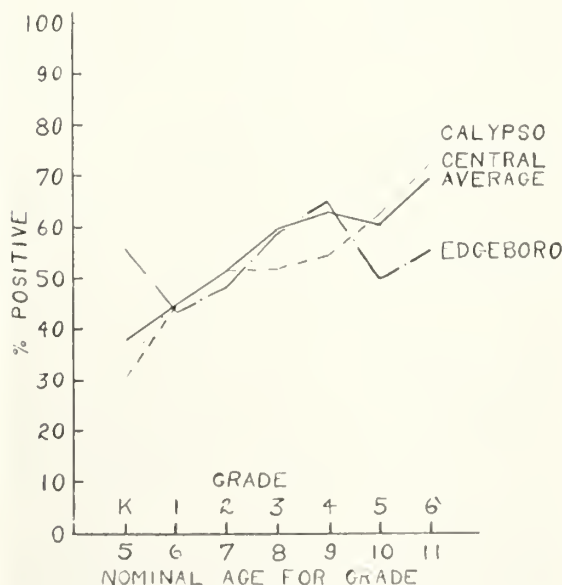


Fig. 2. Schick test survey of Calypso, Central, and Edgeboro Schools in June, 1948.

vided, more attention must be paid to the Schick test.

Many parents do not understand the necessity for a single or repeated Schick tests. There has been tremendous publicity regarding immunization, but not nearly enough regarding the importance of the Schick test. This lack of understanding, unfortunately, has been fostered by all too many physicians whose attitude is that "shots will immunize most of the children. Why bother to Schick-test them all in order to find the few that are not immune." Also, there are many parents who do not bother or forget to bring their children to their family physician for Schick-testing.

The preschool child represents a difficult age group to reach. It is only through the efforts of the family physician and the social service agencies that these children can be reached. Those not immune should receive sufficient inoculations at appropriate intervals until a negative Schick test is obtained. All of these children should receive a Schick test before entering school.

Beginning at school age, Schick-testing should be done at intervals of two to three years. In this manner a constant check should enable us to maintain almost a 100 per cent immunity in school children and adolescents.

Summary

1. Nine cases of diphtheria occurring in Bethlehem and its immediate vicinity are reported.
2. A total of 958 children of school age were Schick-tested in 1945 with a mean average of 46.7 per cent of positive reactors.
3. A total of 748 children of school age were Schick-tested in 1948 with a mean average of from 37.9 to 69.4 per cent of positive reactors.
4. The importance of the Schick test is stressed.

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A GOOD DOCTOR

How does one become a good doctor? When one doctor says of another, "He is a good doctor," there is a particular meaning. You will hear the expression used not only about some general practitioners but also about some specialists. As I understand it, a good doctor is one who is shrewd in diagnosis and wise in treatment; but more than that, he is a person who never spares himself in the interests of his patients; and in addition he is a man who studies the patient not only as a case but also as an individual.

Diagnosis and treatment are of course the basis of our work with patients. We learn these subjects day in and day out as we walk the hospitals, and we have to pass examinations in them. I do not propose to discuss them except to emphasize that after graduation none of us is infallible; if we accept this fact and are prepared to go on learning, our mistakes will tend to become less frequent and less serious.

How does one learn to devote oneself unsparingly to one's patients? You cannot get this from books or from formal clinical instruction. It is something which is passed on from one generation of doctors to the next, and the easiest way to acquire it is to work with a doctor who already has it in his blood. Lister, for example, was a good doctor; he used to visit his patients in King's every day, including Sundays, and his eminence and his preoccupation with research did not

prevent him from showing great understanding and consideration of their feelings.

Your patients need from you more than diagnostic and therapeutic efficiency. They do not come to you to be cured; they come to be relieved of their pains and other symptoms and to be comforted. Given the choice, they would usually prefer a kind doctor to an efficient one. Never forget that the patient and his relations are usually frightened and anxious—upset in their normal life to such an extent that they are prepared to call you into their lives and to tell you the most intimate facts about themselves, though you may be unknown to them except as a member of an honorable profession. In their anxiety, especially when things are not going well for them, they may on rare occasions be rude to you and offend your dignity. This may be hard to bear, especially in the early days of one's medical life before one has lost one's self-consciousness at the bedside and has become wholly familiar with clinical technique. Under such trials you must humble yourself and continue to treat your patient with consideration and kindness, never forgetting for one moment that he is an anxious and overwrought individual, and that in seeking your advice he has paid you the compliment of admitting you to his life and confidence.—Excerpt from "On Becoming a Good Doctor," by Sir Hugh Cairns, which appeared in the October 8 issue of *British Medical Journal*.

MANAGEMENT OF PREMATURE LABOR

WALTER E. STARZ, M.D.

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APPROXIMATELY 70 per cent of neonatal deaths occur in premature infants and in presumably mature infants whose weights do not exceed greatly the weights of the truly premature, namely, 1500 to 2500 grams. The incidence of prematurity varies between 3 and 10 per cent of total births; hence a reduction in the mortality of such a large class of infants is the surest method of decreasing our gross mortality rate. Such a reduction is essentially diphasic; it involves the prevention of premature labor and the management of such labor when it occurs. This discussion will not concern itself with the preventive aspect of the problem other than to briefly mention that the intelligent management of the hypertensive toxemias, cardiac disease, syphilis, diabetes, placenta praevia, premature separation of the placenta when not too extensive, multiple pregnancy, and breech presentations will frequently permit of the prolongation of the pregnancy and thus definitely decrease the fetal mortality in these complications.

With the onset of premature labor the patient should enter the hospital at once. An accurate evaluation of the general status of the patient is essential to the intelligent management of her labor. In the management of the elderly primigravida or the patient who has been a sterility problem for several years, there may be a choice of elective abdominal delivery. In the younger patient and in the multipara a diagnosis of position and presentation, fetal size, and vital status will be definite factors in our choice of total analgesia, anesthesia, and the mechanics of delivery. When labor is complicated by vaginal bleeding, transfusions may reflect their benefit in maintaining an adequate oxygen-carrying capacity, thereby decreasing the degree of intra-uterine fetal anoxemia.

The following specific principles will be of value in the management of premature labor:

Vitamin K should be administered in 10 mg. dosage early in labor and may be repeated in similar amount every eight hours. The value of this vitamin is open to question, but its empiric use can do no harm.

The most important single factor in premature labor is the management of analgesia and anesthesia. A frank discussion of the potential dangers of deep sedation and anesthesia will frequently arouse in the patient a desire to assist in the successful outcome of the process for which she has waited and planned. Barbiturates and morphine, in our opinion, should be withheld because of their depression of the respiratory centers of the fetus. We advocate demerol (50-100 mg.) administered at three to four hour intervals. Caudal analgesia may be used if skilled personnel are available.

At delivery, nitrous oxide-oxygen analgesia during the actual uterine contractions, followed by oxygen in the intervening intervals, will insure the fetus adequate oxygenation. As the presenting part of the baby impinges on the perineum, simple infiltration of the perineum with $\frac{1}{2}$ to 1 per cent novocain solution in the line of the projected episiotomy or the administration of pudendal block will provide adequate local anesthesia.

The routine use of episiotomy is firmly advocated. The fetal head in premature infants is more vulnerable than in the mature baby. Any decrease in resistance to the expulsion of the head will be reflected in a definitely lowered incidence of intracranial hemorrhage.

The use of prophylactic outlet forceps has many adherents. When carefully used, without compression and simply to control the rate of expulsion of the head and to assist in extension, we have found their use advantageous.

Breech presentation occurs approximately four times as often in premature labors as in mature labors. One must remember that the diameters of the premature fetal head are larger than those of the shoulders, hence delay in extraction is ad-

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vocated until one is assured of adequate cervical dilatation. The extraction of the aftercoming head through an inadequately dilated cervix is an experience which once attempted is not usually repeated.

For abdominal delivery the use of local anesthesia supplemented with vinethene or pentothal for incision of the uterus and closure is a very satisfactory method of insuring the delivery of a vigorous baby.

SHOE FITTING FLUOROSCOPES

No disasters have been reported from the use of fluoroscopes in shoe stores—no radiation ulcers, cancers, or arrests of epiphyseal growth. Nevertheless in medical practice more and more bad effects are being reported years after use of radiation. This has been commented upon editorially in the *Journal of the American Medical Association*. Physicians are becoming more aware of the hazards of radiation and more impatient with its use in uncontrolled situations or for purposes where something less hazardous would serve. Although shoe fitting fluoroscopes have been widely used for more than two decades, it is only in the past few years that a movement to regulate them has been active.

The handbooks on x-ray protection of the National Bureau of Standards do not mention shoe fitting, but the American Standards Association in its Safety Code for Industrial Use of X-Rays, Z-54.1, 1946, sets 2 r per exposure (to the foot) as the permissible limit.

An editorial in the *News Letter*, February, 1948, related how the New York Roentgen Society had condemned the machines some ten years before and had at last obtained the help of the New York Academy of Medicine in prodding the city's Board of Health into regulatory action.

A few months later the National Shoe Retailer's Association turned to the American College of Radiology for advice. Dr. G. C. Henny made measurements on seven machines in Philadelphia and Dr. F. E. Hoecker provided some measurements (five machines) he had made in Kansas City. These showed cutoff times of 12 to 27 seconds, and dosage rates from 10 to 140 r per minute. The College thereupon sponsored a warning editorial which was published in the *J. A. M. A.*, Volume 139, page 1004, dated April 9, 1949. This was reprinted by the National Shoe Retailer's Association and sent to its five thousand members. Williams and Hempelmann each wrote an essay on the hazards of fluoroscopic shoe fitting, and recommended a limit of 1 r per viewing, twelve times per year. This is half the A. S. A. Code limit. Abbott Laboratories in their slick throw-away sheet "What's New" gave two pages to the problem, with a cartoon and good bibliography. The California State Department of Public Health became concerned and collected data from forty machines.

Various maternal complications are responsible for premature labors. These complications must be treated during labor if such treatment does not unduly jeopardize the fetus.

An increase in the incidence of postpartum hemorrhage is usually due to the retention of placental tissue. Prophylactic search for deficiencies in the placenta should be even more carefully performed than following full-term delivery.

They recommended a limit of 12 r per minute with 5 seconds cutoff, but state, "A very good case can be made for the removal of these devices from commercial shoe stores."

It is the customers' feet that are in danger. The shoe fitting machines on the market appear adequately shielded to avoid hazard to shoe clerks and bystanders.

A major manufacturer of shoe fitting fluoroscopes has responded to this public pressure. He has increased the tube distance and set the controls on his machines to bring the exposure at the foot within the A. S. A. limit of 2 r per viewing. He is going to the stores where his fluoroscopes are in use and adjusting tube current and filter to bring the old models also within this limit, or down to 1 r per viewing in those cities where this is called for by the local code. He has finished about half of the outstanding machines according to our present information. It is to be hoped that this good work will soon be finished and that all the manufacturers will follow suit. Presumably the shoe stores will now see that they do.

The American College of Radiology recommends that shoe fitting fluoroscopes be operated only by designated personnel, and be kept locked otherwise, not available to operation by customers or casual curiosity seekers.

Physicians must look on all exposure to radiation as something to be avoided, and only tolerated if the good to be expected outweighs the harm to be predicted. There is some question if fluoroscopy is necessary to satisfactory shoe fitting. The members of the American College of Radiology's Commission on Radiological Units, Standards and Protection have stated, "We prefer to have them not used at all." We hear that in some countries where they are in fact interdicted the shoe stores have transparent plastic models of all regular sizes for the customers to try on. If, however, shoe fitting fluoroscopes do continue to be used, it would seem that the limits and controls presently being accepted will give moderately good assurance that no injury to skin or growing bones will follow except after what one would call willful repetition of exposure past all reasonable repetition of an amusing activity. Fatigue usually sets a limit even to the stereotypy of childhood. —Monthly *News Letter* of the American College of Radiology.

Medical Rehabilitation of the Physically Handicapped

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THE BUSY practitioner is concerned chiefly with the physical care of his patients, first with prevention and diagnosis, and second with definitive medical care. The first two phases of practice will run in certain stated lines, but a "third phase" is concerned with the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable.

In our complex civilization there are many advantages to specialization, but on the other hand there are also many disadvantages. The practicing physician is confronted with the problem of following through to the completion of his medical management and, therefore, time and the expense to the individual become factors of extreme importance. From a practical medical standpoint, the management of the hemiplegic patient is most distressing. Should the patient recover full function, both physically and emotionally, no problem exists, but this is the exception and not the rule. It has been estimated that there are 1,250,000 hemiplegic patients in this country who may be classified as forgotten people. The purpose of this report is to offer a few simple measures for the difficult convalescent period for them.

Too often, where distance and time are factors, it is impractical and expensive to call in expert physical and occupational therapists. American ingenuity can be utilized by the physician, as well as by members of the family, to participate in this phase of medical care, thus simplifying and relieving the practitioner and the family of an expensive, tiresome, and lengthy burden. For all practical purposes, hemiplegia following apoplexy is a common neurologic disability. In this respect the causes of apoplexy in order of frequency are (1) thrombosis, (2) hemorrhage, and (3) embolism.

It is the sole responsibility of the clinician to determine when rehabilitation should begin. Since thrombosis usually causes less damage, active convalescent care should proceed as soon as consciousness returns. In case of hemorrhage, however, physical restoration should be limited to bed activities alone for the first three or more weeks, depending upon the patient's condition. Finally, active rehabilitation may begin as soon as the patient with an embolism regains consciousness provided there are no other systemic contraindications. To prevent later complication, definitive medical care should include these few simple rules:

1. A footboard or posterior leg splint should be used to prevent foot drop or contracture.
2. Sandbags should be placed along the outer edge of the affected leg to prevent external rotation.
3. A pillow should be placed in the axilla to prevent adduction of the affected shoulder.
4. A splint made of wood, well padded, may be used to prevent contracture of the fingers and wrist.

When the patient has recovered sufficiently to understand direction and is physically able to tolerate a small amount of bed exercise, quadriceps settings should be inaugurated to maintain muscle strength. It is wise to raise the patient's trunk so that balance will be re-established (Fig. 1). Thus far, the measures have been preventive, but failure to follow these rules will delay and complicate recovery. If there are no contraindications such as rapid pulse rate, hypertension, exhaustion, etc., it is wise to begin active graded exercises to prevent the severe disabilities of muscle contracture. For this purpose, a simple pulley mechanism can be constructed in the home to permit motion of the affected arm or leg or both. First of all, a simple overhead frame constructed of 2 x 4 lumber (or pipe) and supported at each end of the bed with verticals can

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Fig. 1. Teaching patient to balance while in bed.

be built (Fig. 2). A section of clothesline is passed through a pulley attached to this overhead. At the end of the clothesline two small pieces of broomstick may be used for handles (Fig. 3). If the patient's hand has shown no return of function, a sling may be made of muslin to support the hand and wrist during this pulley therapy. This simple device is efficient and economical.

At this point I should like to discuss the problem of rapid deterioration of shoulder muscles in relation to pain in that area. Anatomically, the pectorals anteriorly and the latissimus dorsi posteriorly arise from the thoracic wall and insert into the upper portion of the humerus. With disuse, these large masses contract rapidly and render the deltoid, a small muscle by comparison, ineffective to abduct the arm. Usually the patient will elevate the affected shoulder when attempting abduction of the arm; this in turn leads to spasm and painful involvement of the trapezius. The hemiplegic frequently complains of painful shoulder, especially in changing position or during the time that should be devoted to sleep. Actually, there is no comfortable position in which a painful shoulder may be maintained for any length of time. The prevention of muscular contracture will eliminate pain whether or not function of the arm returns. It is not uncommon for a diagnosis of root pain or other neurologic complaint to be made since muscle contracture is the cause. Root involvement can occur in certain cases, but the clinical records (hospital)¹ used for this study indicate that root involvement is the exception rather than the rule. Passive movement of the arm and shoulder by a member of the family, under supervision and instruction of the physician, will prevent these distressing and annoying after-effects.

This simple pulley activity not only aids in the prevention of muscular contracture but at the same time provides an occupation which relieves the boredom of chronic illness. Although foot drop commonly results from a stroke, prevention of an Achilles' shortening will make the fitting of a prosthetic device a simple matter.

Pulley therapy should be continued with the patient in bed to increase the length of the muscles of the arm and shoulder (Fig. 4). Quadriceps may be strengthened by a straight leg raise in bed, on the floor, or by lifting weights from a sitting position. These exercises may be performed by the patient before and after leaving his bed upon the recommendation of his attending physician.

Besides the physical damage, we should consider the emotional stress through which such patients must pass. It is not difficult to imagine an active robust human animated with a zest for living who is suddenly stricken with apoplexy and becomes an invalid. These patients become morbid, avoid friends and family, and have emotional and even psychic changes of varying severity. When they are permitted to engage in the simple exercises described, it is well to utilize everyday home ideas such as wiping dishes, cutlery, or pots, even though they lie in bed. They thus derive a feeling of usefulness to the family and household without the depressing feeling of being helpless. It is interesting to note how the thread of living is maintained and continues when they are able to be up and around. To assist in ambulation, their gait training may be furthered by lining chairs back to back which



Fig. 2. Simple frame over bed for hemiplegic.

offer support to the individual and do not call for the construction of expensive equipment, such as parallel bars.

At this point consultation with an orthopedist or physiatrist is indicated for any necessary prosthetic device. The question of speech therapy cannot be discussed in this brief report, but we have seen such patients respond very satisfactorily to simple methods of training. It has been observed that as the ability to speak and think progresses physical endurance and coordination increase. Although one cannot furnish concrete evidence for this statement, it has occurred so frequently as to warrant careful consideration.

One of the most distressing disabilities occurring in everyday living is the painful shoulder produced by causes other than hemiplegia. The diagnosis of subdeltoid bursitis, based on the presence of pain in the scapula or upper arm, is made too frequently. The acute phase of this disability lasts but a short time, but the complications which follow are more severe than the original involvement. Movements of the shoulder become painful, especially abduction, internal and external rotation. Radiation of pain from the shoulder to the wrist and hand, numbness, tingling, and even edema are not unusual even when the shoulder is kept at rest. Actually, the latter resemble root involvement, but careful neurologic and roentgenologic examinations fail to reveal definitive pathology. Further, the supraspinatus and trapezius muscles share in this process and their involvement eventually leads to the serious diagnosis of "frozen shoulder."

Shoulder pain produced by causes other than hemiplegia may result from a sudden pull on the shoulder structure, such as opening a jammed door or window, a severe jerk by lifting or pulling a resistant heavy object. It is particularly common among athletes, especially in throwing a football or baseball. Persons not physically prepared for athletic activity at any age, but

especially among older people, run the risk of acquiring a shoulder injury which may prove troublesome. While this disability appears complicated, usually it is reasonably serious only if the mechanics of shoulder injury are not known. In throwing, the muscular mechanism propels the object with a force equivalent to the strength, length, etc., of the shoulder muscles. The trapezius and supraspinatus act as a recoil mechanism of a gun; if these muscles are elastic and supple, the danger of tear in the latter and/or the deltoid is greatly minimized. Pain is present over the posterior portion of the deltoid and the insertion of the supraspinatus and can be verified by grasping the patient's relaxed arm and pulling it forward. The shoulder is placed at rest, heat is applied by shower, bathtub, hot towels, or radiant heat, and the acute phase of the disability passes. The pectorals and the latissimus dorsi begin to contract within a few days and the problem of a "tight shoulder" follows.

When the early symptoms have subsided, the pulley device designed for the hemiplegic shoulder can be used to the same advantage (Fig. 5). Since individuals with painful shoulder tend to elevate the scapula, it is wise to perform these exercises before a mirror so that the patient can observe the relationship of the upper arm to the shoulder. This habit of elevating ("hiking") an affected shoulder is more easily overcome in the early rather than the chronic phase. The patient should be advised to go to and not beyond the point of pain in performing these pulley exercises. Since the pectorals and the latissimus dorsi are affected, they will thus stretch painlessly to their complete length.

These following rules are of inestimable benefit:

1. Any muscle or group of muscles, irrespective of location, should be gradually stretched to complete length. Failure to observe this rule usually results in a recurrence of the injury should the muscular mechanism be called on for additional stress.
2. Shoulder and arm involvement is more susceptible to lower temperatures (chilling), causing extreme discomfort and retarding the rehabilitation process. Therefore, the patient should be advised to avoid exposure of a painful shoulder to a cool or cold temperature.
3. Experience has shown that the shoulder muscles can be stretched with minimum dis-



Fig. 3. Home-made, improvised adjustable pulley.



Fig. 4. Pulley exercises for hemiplegic patient in bed.

comfort by (a) complete forward flexion, (b) abduction of arm, and (c) external rotation. (N.B. This order is suggested since it progresses from the least to the most painful exercise.)

In the last several years early ambulation has attracted considerable attention, but it is not a new idea. In 1886 Lucas-Championniere² advocated early movement, indicating that immobilization delays pain which becomes worse the longer mobilization is delayed.

In 1889 Reis³ permitted his vaginal celiotomy patients to get up in 24 to 48 hours and discharged them in 6 days.

In 1907 Boldt⁴ reported that for 15 years he had advised his vaginal hysterectomy patients to get out of bed in 24 hours postoperatively.

In 1927 Robertson⁵ reported that 90 per cent of his appendectomy patients were ambulatory within 24 hours and sent home on the third day.

In 1941 Powers⁶ reported a series of cases including hernioplasties, cholecystectomies, and pelvic surgery in which the average hospitalization for the early ambulatory patients was 10.3 days and for the control patients kept in bed 16.1 days. The average period of convalescence after surgery in the ambulatory cases was 5.7 weeks, and in the controls 10.3 weeks.

Leithauser⁷ reported 15,000 cases and found only four instances of fatal pulmonary embolism resulting from early ambulation. At the time of publication, he had performed 900 major surgical procedures with an average of 1.3 days in bed and 4 days in the hospital. There were 4 deaths.

Elman⁸ started a period of bed activity imme-

diately after surgery, consisting of breathing activities and calisthenics for the upper and lower extremities. In 79 patients in this program there were no wound or pulmonary accidents. In the control group there were two wound involvements and three pulmonary embolisms with two deaths.

Blodgett and Beattie,⁹ reporting 681 cases of major abdominal surgery, analyzed the postoperative complications and their causative factors. Those patients who rose early were stronger and had less pain. They were able to care for themselves on about the fourth postoperative day and were discharged earlier than the control group.

Harrison¹⁰ doubts the value of absolute bed rest in cases of coronary occlusion beyond two weeks after subsidence of acute symptoms.

Levine¹¹ observed that enforced recumbency may actually increase the heart load during cardiac failure.

Ancl Keys¹² studied the problem of excessive rest in a group of conscientious objectors who were not disabled and met all the physical requirements of our armed forces. These men were studied under carefully controlled conditions of bed rest for six weeks. He reported that their reaction time was reduced 5 per cent, coordination was markedly decreased, blood vol-



Fig. 5. Pulley therapy from overhead door.

ume was reduced from 10 to 20 per cent, and the heart size was reduced about 11 per cent. Using a standard work test after bed rest, there was a reduction of cardiac effectiveness with a relative tachycardia at rest and in work tests. Work which formerly caused a pulse rate of 125 caused an increase to 170 on the first day after prolonged rest. It required approximately 60 days for the patient to recover a normal pulse rate for the same work load. The author also noted that it is difficult to keep a patient in positive calcium balance and that more than twice the amount of protein is necessary to maintain normal nitrogen balance during this period.

In a rheumatic fever control program, Karpovich¹³ and his associates performed physical fitness tests on convalescent patients. Graduated physical fitness tests were designed which could be used in conjunction with the usual clinical observations in an attempt to determine the rate of increasing physical activity. For those patients participating in this study there was a reduction of 77.3 days to 16.2 days in the beginning of physical reconditioning with no evidence of cardiac damage, despite the fact that these individuals were under observation from six to twelve months. Such application of prompt reconditioning of bed cases can be applied to all medical specialties and will result in a reduction of "bed days," permitting a greater turnover in patients and aiding in making more hospital beds available in our crowded institutions.

Shands¹⁴ points out that Hippocrates and Galen were leaders in this concept and feels that the basis for prevention of deconditioning is an active régime of exercise and employment. In other words, it may be paraphrased by stating that it is purposeful activity started at the earliest possible moment.

It would require too much time to completely describe such bed exercises, but deep breathing will prevent a lowered vital capacity and assist in maintaining a higher volume of circulating blood. Graded purposeful movements of the unaffected parts prevent this deconditioning process and simplify the problem of convalescent care. The principle of early ambulation is no longer theoretical since it proves that the deterioration process is stopped before it actually begins.

One note of caution should be sounded: the

limits of such physical activity, in or out of bed, should be set by the physician or surgeon handling the case since he is best qualified to judge the good or bad effects of such a program. A simple understanding of body mechanics and physical fitness can determine the rate of progress. Thus the physician in charge, whether he be a general practitioner or specialist, can accept the responsibility adequately and take the patient from bed to job.

Conclusion

The author has attempted to demonstrate the following criteria for medical rehabilitation:

1. All hemiplegics are not permanently disabled.
2. Simplicity and economy of mechanical devices will assist in the rehabilitation of such cases.
3. Common shoulder injuries are frequently and incorrectly diagnosed and the treatment of such disabilities follows definite lines.
4. Early ambulation, a form of rehabilitation, prevents the deconditioning process. It is the obligation of the physician wherever possible to direct and lead his patient from the point of injury or illness to the final phase of physical restoration—his job.

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The Value of Psychosurgery in Mental Disease

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THE INTRODUCTION of surgery into the treatment of any illness, especially if that illness be of a chronic, non-fatal variety, requires a careful study of the conditions under which surgery is to be advised. What will the eventual outcome be under less radical types of therapy? What price will the patient pay for his surgery in terms of impaired function? Mental illness is a sad and tragic situation. In numerous cases the outlook is entirely hopeless. Any type of treatment which promises improvement in a fair percentage of cases seems justified. Many of these patients are the living dead, shut away from any pleasurable human contact, and a great expense to their friends or the taxpayer.

At present there are roughly 36,000 mentally ill patients in Pennsylvania alone and the cost to the Commonwealth during the last biennium (1947-1949) was \$47,383,000. If surgery can relieve even 30 per cent of these people and make it possible to return them to their families sufficiently improved to require the minimum of care and observation, the contribution to the general welfare will be immense.

In a recent review of the literature on this subject a number of points were impressive. In the first place the diagnosis of the type of mental illness that the patient has seems more open to question than is the case in the practice, for example, of cardiology, gastro-enterology, or neurology. The field of psychiatry has so far developed relatively few accurate clinical tests separating one type of mental illness from another, and receives little or no help from the laboratory studies employed in general medicine. The personal opinion and clinical experience of the observer seem to be the important criteria and the experts may differ widely. And, unfortunately, postmortem studies do little or nothing to clear up the uncertainties.

The reason for stressing these points is that, if

surgery is to be used intelligently, facts must be had as to the types of cases in which this admittedly radical treatment will be most useful. If the psychiatrists cannot agree among themselves whether a case falls into one or another group, the comparative assessment of surgical results is difficult. Furthermore, unless the surgeons and their neuropsychiatric guides can decide precisely in what area and to what extent the brain should be sectioned to produce the most satisfactory outcome in the various types of mental illness, operative intervention will be less effective than it should be.

In addition to the uncertainties in psychiatric diagnosis, four types of surgical procedures are at present in use: prefrontal lobotomy, lobectomy, topectomy, and thalamotomy. To select the proper surgical technique to produce the most effective result upon whichever of the various types of mental illness may be present will require a vast amount of carefully controlled investigation and the most exact and prolonged observation of these patients postoperatively.

One fact seems to be slowly emerging as surgical experiences increase. The larger the amount of frontal lobes extirpated, the more marked the decrease in the patient's initiative and drive, the greater the loss of emotional motives and associated judgment of values, and the more pronounced the reduction in creative imagination. The intelligence quotient may not be altered, but the urge and desire to use that intelligence are much reduced. Furthermore, the operative procedure carries at least a 5 per cent mortality rate and the more mutilating surgical procedures, lobectomy and topectomy, a good 10 per cent of convulsions.

The general public has been led to believe, through articles in popular magazines, that the surgeon can cure mental illness and that their loved ones following psychosurgery will be able to leave the hospital and be restored to their former place in the family and in society. That

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this is far from true, a review of the recent literature will soon reveal. Roughly 40 per cent of the schizophrenics are improved. Freeman,¹ who has had the largest experience with lobotomy and the advantage of the longest follow-up period in interpreting his results, has recently published the following figures:

<i>Diagnosis</i>	<i>No. of Patients</i>	<i>Good Result</i>	<i>Fair Result</i>	<i>Poor Result</i>	<i>Operative Deaths</i>
Involuntal psychosis	147	55%	28%	15%	2%
Obsession	125	71%	19%	6%	4%
Schizophrenia	332	41%	42%	16%	1%

Freeman and Watts have always used the simple closed method of prefrontal lobotomy. Reitman² and Rothschild and Kaye³ published parallel figures.

TABLE I
SCHIZOPHRENIA
(39 Cases)

10 discharged from hospital	26%
8 apparently able to conduct their own affairs	
2 require nursing companionship (7 closed operations and 3 open operations)	
12 hopeless deterioration—operated upon to make hospital care easier	29%
10 condition much improved	
2 condition unchanged (5 closed operations and 7 open operations)	
17 entirely unchanged by operation—continued hospitalization in every case	45%
(12 closed operations and 6 open operations)	

From England comes a report of the Board of Control on prefrontal leukotomy.⁴ While no definite statement is made, it is to be presumed that the lobotomy is carried out by the closed method. This report covers the results in 1000 cases with an average twelve-month follow-up. In the whole group 24.8 per cent were discharged as recovered and 10.5 per cent as improved, or 35.3 per cent of the entire group subjected to surgery. Among this group 9.3 per cent relapsed. Improved and easier to handle in the institutions were 32.3 per cent with 3.7 per cent of relapses. Unchanged by lobotomy were 24.8 per cent with 1 per cent made worse by the procedure. The mortality was 6 per cent with a 3.3 per cent incidence of postoperative convulsions. Separating these 1000 cases into the various types of mental disease, the schizophrenic

group, which comprised 60 per cent of the total number of cases, gave a discharged cured or improved rate of 23 per cent excluding the relapsed cases. The discharged cured or improved rate in the manic-depressive group, comprising 25 per cent of the series, was 50 per cent excluding relapses. In 958 cases the social behavior was

noted as unchanged in 244, milder in 295, co-operative in 166, living as citizens 242, and worse in 11.

A report from the Connecticut Lobotomy Committee⁵ on 200 cases including 163 of schizophrenia, 10 of manic-depressive psychosis, 8 of involuntal psychosis, and 4 of psychoneurosis, is worth detailed study. In all but 7 cases the open or Lyster surgical technique was used. Only patients believed to be chronically ill, who had not responded to other forms of treatment and who were not likely to recover in the future, were selected. At the end of six months, 43 in a group of 124 schizophrenic patients (33.8 per cent) were at home and 15 among 27 non-schizophrenic patients (37.4 per cent) had improved sufficiently to leave the institution. The mortality rate was 4 per cent: the incidence of epilepsy 7 per cent. Three patients were essentially vegetative after lobotomy.

Further details on the results of prefrontal lobotomy are given by Poppen⁶ and by Petersen and Love.⁷ Poppen reports 470 cases with 5 deaths and 10 per cent of subsequent epileptiform convulsions. In the dementia praecox group 20 per cent were able to leave the institution and make a living; 37 per cent were improved; 43 per cent were unchanged. In this involuntal melancholic group, 55 per cent of the patients could leave the hospital, 33 per cent were im-

TABLE II
MANIC-DEPRESSIVE STATE
(19 Cases)

10 discharged from hospital and able to conduct their own affairs	55%
2 hopeless deterioration; operated upon to make hospital care easier	10%
(2 cases much improved)	
7 entirely unchanged by operation	25%
(15 closed operations and 4 open operations)	

TABLE III
OBSESSIVE AND COMPULSIVE STATE
(7 Cases)

5 discharged from hospital	70%
1 improved in hospital	15%
1 unimproved in hospital	15%
(5 closed operations and 2 open operations)	

proved, and 12 per cent were unaffected. Petersen and Love, without classifying their patients, simply state that, of 240 cases, 72 made a social adjustment, 104 were much improved, and 58 remained unaltered. Ninety-two or 38 per cent of this series were discharged from the hospital. The mortality was 3 per cent, as was the incidence of epilepsy.

Our own figures represent a small series of 76 cases, although all have been followed for one to ten years. The figures parallel quite closely those already given. In the schizophrenic group 10 or 26 per cent of 39 cases have left the hospital and are living at home (Table I). In the manic-depressive group 10 of 19 or 55 per cent have been discharged from the institution and are conducting their own affairs (Table II). In the obsessive-compulsive group of 7 individuals, 5 or 70 per cent have been released (Table III). In a group of 5 mentally deficient children whose temper tantrums and uncontrollable behavior made them very difficult to handle, 4 have been cooled off and made satisfactory members of their group (Table IV). In 6 patients with inoperable cancer and intractable pain, the pain was completely relieved in three, partially in two, and unaffected in one (Table V). In this group of 76 cases, 4 operative fatalities occurred. In 3 of 35 open operations, fits have appeared (9 per cent) as compared to 1 in 41 closed procedures—2.4 per cent (Table VI).

The proper selection of the type of patient for surgery rather than the surgical technique employed seems important. Kalinowsky and Scarff⁸ feel that the suitability of the patient for lobotomy depends upon the intensity of his emotional reactions to his abnormal experiences. In the schizophrenic group the paranoid and catatonic individuals are much more likely to be

TABLE IV
MENTALLY DEFICIENT CHILDREN WITH TANTRUMS
AND ASSAULTIVE BEHAVIOR
(5 Cases)

4 much improved—easier institutional care
1 unimproved
(2 closed operations and 3 open operations)

benefited by surgery than the hebephrenic group. The affective disorders, manic-depressive psychosis and involutional melancholia, hypochondriasis and psychoneurosis, together with the obsessive-compulsive neurosis, are improved. But it must always be remembered, at a price. Surgery should always be a last resort. No patient with mental illness should be subjected to surgery until all other conventional methods have been proved useless by thorough trial. And when surgery seems indicated, its results and benefits should not be exaggerated. Unquestionably, prefrontal lobotomy is of much value in reducing emotional excitability and behavior disturbance, thus making the institutional care of

TABLE V
INOPERABLE CANCER WITH INTRACTABLE PAIN
(6 Cases)

3 complete relief—no opiates
2 partial relief—opiates required
1 no relief of pain
(All open operations)

assaultive patients much easier and reducing possibly the number of attendants necessary.⁹ This may well reduce the financial burden of mental illness. Unquestionably, the mental suffering that many of these patients undergo is materially lessened. But this result may not satisfy the relatives who want the patient released from the institution and the stigma of mental illness removed from the family. And many of these patients recorded as discharged from the hospital are problems at home, mild problems no doubt, but still requiring tact and forbearance on the part of the family to make home life possible for them.

After psychotherapy, electroshock, or insulin shock have failed to produce permanent results, a surgical attack on the frontal lobes will without doubt better the condition of many people suffering from mental illness. Roughly 30 per cent of these people are sufficiently improved to warrant discharge from the hospital; another 40 per cent are much more easily cared for within the institution. Twenty-five per cent are unimproved and 5 per cent will succumb to the surgical procedure. Postoperative epileptic attacks will be noted in from 5 to 10 per cent.

The saving to the taxpayer in the reduction of the expense of mental illness would be great. The State of Pennsylvania should follow the example of the State of Connecticut and set up a commission to study the effects of lobotomy and

TABLE VI
COMPLICATIONS
(76 Cases)

41 closed operations and 35 open operations	
Mortality 4 cases	5.3%
2 closed operations and 2 open operations	
Convulsive attacks 4 cases	11.4%
3 in 35 open operations	9.0%
1 in 41 closed operations	2.4%

to coordinate the efforts of psychiatrists and neurosurgeons in selecting the proper cases for operation and the proper operation for the specific type of mental illness. Only in this way, by active cooperation of a number of groups working along principles previously agreed upon, can the results of the surgical treatment of mental illness be accurately evaluated. Once the facts are clear, a vigorous attack should be made upon this problem so that the burden of supporting these persons may in some way be lifted from the taxpayers of this State.

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ABSTRACT OF DISCUSSION

HOWARD K. PETRY (Harrisburg): Being a mere psychiatrist, I do not wish to discuss the technologic problem which Dr. Grant has presented to us, but it is a matter which should be interesting to all of us as citizens of this Commonwealth. In the mental hospitals of Pennsylvania there are at the present time some 38,000 patients. At least half of that number are definitely within the chronic grouping. If in this treatment we have a measure that may reduce the necessity for institutional care for an appreciable number of this group, it should be given careful consideration.

Speaking now from the standpoint of public relations, which you in this Society know I am vitally interested in, it seems to me that we in medicine have a definite obligation at the present time and an opportunity to bring credit to our organization by demonstrating to the public the fact that we as organized medicine are

benefactors of society. I want to emphasize particularly what Dr. Grant said in his closing remarks. I think that our Committee on Mental Hygiene, headed by Dr. Eaton, should take an active interest in the suggestion that we set up a committee or commission within the State to evaluate this treatment and determine whether we can make a definite contribution to the body politic and bring to organized medicine the credit for doing something as a group for the public on this great issue.

YALE D. KOSKOFF (Pittsburgh): It is a pleasure to discuss this level-headed and authoritative paper. At once we can say that Dr. Grant has his feet on the ground although his hands may be in the frontal lobes. I agree with him that so often in frontal lobotomy we must keep in mind that there is a limited objective, and I think one of the criticisms of lobotomy is derived from the fact that too much has been promised and too little delivered.

Dr. Grant's interest in lobotomy with Dr. Edward A. Strecker stems from an important series of reports beginning in 1941 and 1942 in which he said that the relief from lobotomy is essentially a "relief from apprehension." I think that there is not much that we can add to that succinct interpretation of the emotional affective side.

I should like to ask Dr. Grant whether he still underwrites this rather unfair quotation from a previous communication.

The second point that I should like to raise is this: On the basis of his present experiences, particularly in the assaultive group, would Dr. Grant care to include aggression as a behavioral characteristic which may be consistently relieved? In a study of patients at the Western Psychiatric Institute here in Pittsburgh, with Torrance State Hospital collaborating, we found that 66 per cent of the patients were relieved of symptoms of aggression. This group of patients was selected particularly because they were homicidal, assaultive, and aggressive. In our hands that symptom was most consistently relieved by standard lobotomy.

I raise the question on a symptom basis because, as Dr. Grant ably pointed out, diagnostic categories fall down, and we have found that on an analysis of symptoms we seem to be able to get a somewhat better understanding of our results. If we can include aggression along with his previous consideration of anxiety or fear, then I believe we shall have made an additional symptom analysis with a certain amount of profit.

On the basis of his experiences with mentally deficient children with assaultive behavior, would Dr. Grant feel that lobotomy may be applied more widely in such institutions to simplify custodial care and to make these patients happier? I raise this question because those of us who are doing lobotomies have been a little timid about doing them on children. There are certain disadvantages there that may not occur in the adult, and apparently the child needs his frontal lobes more than the adult. But then again, if we have a limited objective and plan only to make these patients more acceptable on a custodial basis, would he favor this as a procedure in institutions where feeble-minded children are cared for?

Dr. Grant in his presentation did not state his preference for various surgical procedures because of lack

of time I have a personal interest in his thought on whether or not by doing less than the standard bilateral lobotomy, such as a unilateral lobotomy or an anteriorly placed lobotomy, we may not be able to offer this procedure before a last resort type of measure. I recognize with him the fact that, if we take away less brain substance, capacities may be less interfered with. In other words, can we offer a simpler operation on the lobotomy basis by cutting frontal association pathways without resorting to more difficult procedures such as topectomy or the other types which Dr. Grant mentioned? As a surgeon, I am curious about his own thought on the matter.

I think we would all agree here in Pittsburgh that Dr. Grant's recommendation that a Pennsylvania lobotomy commission be established is extremely important. Only by cooperation can the fullest value of this procedure in the relief of mental disease be achieved.

DR. GRANT (in closing): Dr. Koskoff has asked a number of pertinent questions.

In the first place, about the children, the qualification that we have used for prefrontal lobotomy has been that the children must be from 5 to 10 years of age. You will have noticed that there were only 5 of them in our series, which is not a very large experience. The mental condition of these children was hopeless and they were obviously doomed to institutional care whatever was done to them. I do not believe their frontal lobes were necessary or would have benefited them under these circumstances, but they had become too hot for the institutions to handle—these were all private institutions—and therefore the problem came up as to whether they were to be turned over to state institutions. The families, of course, objected, and we were asked to see if we could do something to render them less assaultive or aggressive. I quite agree with Dr. Koskoff that aggression should be taken into consideration as a symptom. After we removed the frontal

areas, these children became docile and it was possible to take care of them under rather palatial and ritzy conditions that their families could manage.

With regard to the partial lobectomy, I must confess that I have not attempted that. My series is not a very big one—only about 80 cases. I am sure there are plenty of men in the country who have done hundreds of these operations. We have used the two routine standard procedures—the original operation as suggested by Freeman in Washington, which to my way of thinking has very definite advantages and minor disadvantages, and the open operation suggested by Lyerly and more recently popularized by Poppen at the Lahey Clinic, which is the kind of operative procedure that requires a good deal of postoperative care and does not lend itself to institutional postoperative care. It also, incidentally, has a higher death incidence than does the Freeman procedure.

If you are going to do these operations in institutions, you must remember that the institution is probably not equipped or organized to offer the patient the proper postoperative care. Therefore, you must do the simplest operation that is going to do the greatest amount of good. Certainly, in our hands, the original Freeman technique has proved highly satisfactory. As I say, I have not done the modified operation in which the cutting is done below the horizontal line entirely with no cutting above it. There are variations of that procedure which will lend themselves, I think, to profitable examination. But when you talk to men who are doing lobotomies in large number and find them in a confessional mood, I think they will all admit that there is a direct relationship between the amount of brain tissue removed and the result: the more brain tissue you take out up to a point, the better is the result; and when you go beyond that point, the patient is much worse off. Of course, he is quiet and passive, but he is vegetative and has not been bettered by the operative procedure.

Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.—Section 4, Chapter I, Principles of Medical Ethics of the American Medical Association.

TREATMENT OF HYPERTENSION

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IN THE management of patients with high blood pressure a number of questions arise which need to be answered before treatment can be planned intelligently: (1) Should all patients with hypertension be treated? (2) When should treatment be withheld? (3) Under what circumstances is hypertension of danger to patients? (4) When should surgical sympathectomy be resorted to? (5) What types of medical treatment can be used? (6) What specific causes of hypertension can be combatted by medical or surgical treatment? We propose to present in this paper some of our current concepts concerning the management of hypertension.

Evaluation Prior to Treatment

There should be no short cut in the evaluation of patients prior to treatment. Since elevation of blood pressure is only a sign of underlying disease, we have attempted to make as thorough an evaluation of each patient as possible prior to instituting therapy. A complete history, physical examination, blood Wassermann reaction, blood count, and urinalyses, as well as special tests to be mentioned subsequently, are basic to a design for treatment. We have grouped our patients according to their levels of blood pressure as follows:

CLINICAL CLASSIFICATION OF HYPERTENSION

1. Labile
 - a. Predominantly normal values—observation only
 - b. Predominantly abnormal values, higher than 150/90—medical treatment
2. Fixed
 - a. Mild—observation only

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.

From the Edward B. Robinette Foundation, Medical Clinic, and Hospital of the University of Pennsylvania, Philadelphia.

We are indebted to Sandoz Pharmaceuticals, and to Irwin, Neisler & Company, for research grants and for generous supplies of drugs used in this study. This investigation is being supported (in part) by a research grant from the National Heart Institute, U. S. Public Health Service.

- b. Moderate $\frac{160-180}{100-110}$ —medical treatment
- c. Severe—diastolic 120 or more
 - (1) Preservation of renal function
 - a. Above 50%—sympathectomy (?)
 - b. Below 50%—medical treatment
 - (2) Malignant—choked disk, progressive arteriolar damage—treatment as for (1) above

Currently we have centered our attention upon those patients with severe hypertension as particularly deserving of study and treatment. We acknowledge, however, the possibility that those with only moderate elevations of blood pressure may develop dangerous complications.

In our experience the use of a simple postural test¹ gives information which cannot be obtained by random sampling of the blood pressure. It is of particular value in allowing one to follow the effect of certain sympatholytic and vasodilator drugs, and serves to pick out the occasional hypertensive patient who shows a spontaneous fall in blood pressure upon standing.²

We feel that it is important to assess what damage has been done to small arteries in association with the individual's hypertension. This serves as one indication of how well he has tolerated his hypertension, and provides a baseline for subsequent comparison. Examinations in respect to arterial damage include funduscopy, an electrocardiogram, an orthodiagram, a phenol-sulfonphthalein excretion test performed at 15, 30, 60, and 120 minutes, and other more elaborate tests where damage can be assessed only by their use.

During the preliminary evaluation of patients, one should be alert to note any etiologic factor which might have importance in influencing the type of treatment. It is not enough to recognize a large emotional element; one should go further to determine whether or not this factor can be ameliorated by treatment. The history of hyper-

tension in association with pregnancy may point to a renal lesion which is still active. Occasionally, endocrine disorders can be demonstrated to have real importance, as, for example, Cushing's syndrome. Hyperthyroidism rarely need be confused with so-called essential hypertension. We recommend that one be constantly aware of the syndromes produced by an adrenal medullary tumor, and use the benzodioxane test³ where symptoms and signs suggest this possibility. Unfortunately, the test is not infallible.

In the presence of severe hypertension, appropriate further renal studies are performed, such as intravenous urograms and measurements of renal plasma flow and glomerular filtration. Our experience, however, coinciding with that of others, indicates that renal surgery in the hypertensive adult but rarely produces a gratifying fall in blood pressure. Conversely, we have not hesitated to refer for sympathectomy patients with demonstrable renal lesions, if renal function is well preserved. The role of such contributory factors as obesity, syphilis, and diabetes is deserving of mention. Where these are present, they should be treated effectively. By comparing the femoral and brachial pulses in all hypertensive patients, coarctation of the aorta will not be overlooked.

We consider the following factors of importance, therefore, in designing treatment to suit the individual need: (1) specific etiologic factors, if found; (2) the severity and constancy of the hypertension; (3) the age, race, and sex of the patient; (4) the degree of vascular damage, particularly renal; (5) the occupation, habits, and temperament of the patient; (6) important coincident systemic disease, particularly obesity, diabetes mellitus, kidney disease, or syphilis. A patient with mild hypertension may require only periodic observation, while one with marked elevation of the diastolic pressure and azotemia needs treatment directed toward his comfort rather than heroic therapy.

Therapeutic Measures

Because of the frequent association of anxiety and other psychiatric manifestations with hypertension, it is important to give the hypertensive patient the type of psychotherapy which fits his individual need. Through a liaison with the Functional Clinic of the Hospital of the University of Pennsylvania, we have attempted to meet this need for the especially difficult problem. Other more homely procedures should not be

overlooked, such as aiding the patient to improve his habits in relation to tobacco, rest, and relaxation, and to participate in a degree of physical activity which avoids fatigue and sudden strain. The use of small rations of sedatives, such as phenobarbital 15 mg. three times a day, is almost a routine requirement.

We are not in a position to discuss the relative merits of a formal rice diet versus a low-sodium diet. We have used both, with apparent benefit, particularly in the presence of severe hypertension or a tendency to develop evidence of heart failure.

By the employment of repeated postural tests, the effects of the longer acting nitrites can be observed, particularly if the blood pressure is measured while standing. The use of repeated doses of amyl nitrite or nitroglycerin for hypertension seems to us ineffectual and ill-advised. We have employed sodium nitrite, 60 mg. three times a day, or mannitol hexanitrate, 60 mg. three times a day, without producing unpleasant side reactions in most individuals, and with some orthostatic hypotensive effect.

The successful employment of veratrum as the sole therapeutic agent over prolonged periods of time is fraught with considerable difficulty, in our experience. Its disadvantages include a minimal margin of safety between the therapeutic and the toxic dose, and a tendency for its effectiveness to diminish after several weeks of use. We are at present exploring the use of small doses of veratrum in connection with sodium nitrite and phenobarbital.*

Although of demonstrated usefulness in certain patients with hypertension, potassium thiocyanate can safely be used only if the blood thiocyanate level is measured weekly until the patient is controlled, then at intervals of not longer than every two weeks. One should watch vigilantly for such toxic reactions as the production of goiter, the aggravation of anginal pain, or the appearance of dermatoses.

The development of sympathicolytic and adrenolytic compounds has yielded substances which give promise that a true "medical sympathectomy" may some day be available. We have employed dihydroergocornine† and related compounds extensively by both the oral and the intramuscular route. While it is apparent that upon intramuscular administration this prepara-

* Veratrite—Irwin, Neisler, & Company.

† DHO-180—Sandoz Pharmaceuticals.

tion is a potent depressor agent, we are as yet unable to produce as good a response when the tablets are taken by mouth. This drug is not commercially available. It is probable that even better agents will shortly be developed. We have occasionally employed tetra-ethyl-ammonium chloride (etamon) for the treatment of crises of hypertension. One should inject it slowly intravenously with the patient recumbent until a fall of about 50 mm. in systolic blood pressure is obtained. Subsequently, twice this dose can be administered intramuscularly at intervals of from four to six hours.

For those with severe hypertension or a known tendency toward vascular accidents, we use empirically both rutin, 60 to 120 mg. daily, and ascorbic acid, 300 mg. daily.

It is our procedure to refer for the Smithwick type of sympathectomy those patients with severe hypertension who have adequate renal function, are under 50 years of age, and who have failed to respond to the medical measures which we have described above. No test, or combination of tests, has proved of assistance to us in predicting which patients are apt to respond favorably to sympathectomy. With close cooperation between a well-organized surgical and anesthesia team, the operative mortality at the University Hospital has been minimal. We feel that the operation is justified as a last resort in those with severe hypertension and evidence of progressive vascular damage not accompanied by renal failure. It is to be hoped, however, that elucidation of the etiology and pathogenesis of hypertension will soon afford a more basically sound procedure than sympathectomy.

Evaluation of Treatment

The difficulties in determining whether or not a procedure really alters the course of hypertension and its complications are well illustrated by reports concerning the effectiveness of sympathectomy.^{4, 5} These same difficulties are encountered in dealing with various medical agents. Certainly one cannot depend upon symptomatic improvement as a reliable criterion.

When a regimen will produce a prolonged lowering of blood pressure, with attendant relief of symptoms, regression of retinopathy, diminution of cardiac enlargement, and improvement in an abnormal electrocardiographic pattern, it becomes deserving of a critical and extensive trial.

During the past year we have tried by medical means to maintain a reduction of the blood pressure of patients with *severe* hypertension in the hope of averting the need for sympathectomy. We have been successful in only a few instances, by employing simultaneously the several aforementioned therapeutic measures. Further observations will be required to establish whether or not remissions can be maintained for a matter of months or years. By withdrawing individual drugs, or placebo substitution, we are attempting to evaluate comparatively the importance of the separate elements where combination therapy has seemed to produce a favorable response. The necessity of approaching the problem in this fashion emphasizes the ineffectiveness of any single measure which we have as yet employed.

At this point it is in order to indicate more specifically how the measures which we have described can be employed. Upon his initial visit a patient will usually require reassurance if he realizes that his blood pressure is elevated. A thorough examination will go far toward reassuring him that everything is being done to warrant the physician's optimism. Indeed, for the patient with only labile or mild hypertension, and without other disease, such an examination, twice annually, may fulfill his requirement for treatment. We consider it unwise to inform the patient specifically about his blood pressure readings. To tell him entails the risk that his spirits will fluctuate with each new reading, and he may reach totally unwarranted conclusions about the success or failure of treatment.

For those with moderate elevations of blood pressure, one should proceed further to determine from repeated examinations what damage has been done, and attempt to correct any remediable factors noted. Weight reduction is often required among this group and latent diabetes will be found not infrequently upon determining blood sugar levels. Moderate physical activity, such as golf, need not be discouraged, but a period of relaxation for 45 minutes after each meal will be a good investment. Drug therapy may include the nitrites with prolonged action, phenobarbital, and veratrum. If vascular accidents have occurred in the past, rutin and ascorbic acid may be tried empirically. For the relief of anginal pain, nitroglycerin 0.6 mg. should be carried by the patient at all times for sublingual use. Signs of congestive heart failure are an indication for the use of digitalis and a diet with restricted sodium content. It should not be forgotten that

digitalis in full dosage will occasionally produce aggravation of anginal pain.

When a patient has severe hypertension, the physician should be careful not to reveal his concern, but should proceed methodically to evaluate the total picture. Often it will prove to be less alarming than it appeared upon the first office visit. If the treatment as described for moderate hypertension is ineffectual, we employ the strict rice diet and dihydroergocornine or related substances. For patients with preservation of renal function of 50 per cent or more, who are under 50 years of age, the Smithwick type of sympathectomy is advised at this juncture if medical therapy fails and the disease appears progressive. For "crises" of hypertension, tetraethyl-ammonium chloride (etamon) can be used intramuscularly as described. Even if one can do little more than make the patient with severe, terminal hypertension more comfortable, optimism and a willingness to give all possible beneficial measures a trial will insure gratitude for the physician and increase the sum of our knowledge regarding this important disease.

PITTSBURGH MARINE HOSPITAL BECOMES HEALTH CENTER

Transfer of the U. S. Marine Hospital at Pittsburgh from the Public Health Service, Federal Security Agency, to the City of Pittsburgh for use as a model health department center was announced on April 10 by Federal Security Administrator Oscar R. Ewing.

In turning over to Mayor Lawrence the property, which is to be operated as a health center for the people of Pittsburgh by the municipal government with the support and cooperation of the Public Health Service, Mr. Ewing said:

"The principle of state and municipal cooperation in such fields as public health, education, public assistance, social security, vocational rehabilitation, and child health and welfare is a firmly established pattern with the Federal Security Agency. Here, it seems to me, we have an example of this sort of cooperation at its best. Here, the Federal Government and a great city are entering into an agreement to work jointly toward the establishment of better health and well-being for many thousands of Americans in Pittsburgh and Allegheny County."

Mr. Ewing described the proposed operation of the clinic where public health physicians, nurses, and sanitary engineers will work together with private practitioners, hospitals, and the voluntary agencies toward the prevention and control of communicable diseases, and in providing such clinical services as tuberculosis,

Summary

1. For the management of patients with hypertension, an initial classification based upon the levels of blood pressure seems useful as a guide in planning treatment and in evaluating response to therapy.

2. A thorough medical evaluation is essential if pitfalls are to be avoided.

3. The various therapeutic agents which we are currently testing are described.

We are indebted to Drs. Charles C. Wolferth and Francis C. Wood for advice and assistance in conducting this study, and to Miss Nellie J. Keffer for technical assistance.

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venereal disease, and cancer control, dental hygiene, and maternal and child health.

For almost a century a marine hospital has been in operation intermittently in the Pittsburgh area. The present hospital admitted its last patient on Sept. 16, 1949, and was officially closed on October 1 when chronic patients were transferred to other marine hospitals where special facilities and specially trained personnel were available for their care. Since the date of closing, an outpatient clinic for Public Health Service beneficiaries has been maintained at the Pittsburgh Hospital, and patients requiring emergency hospitalization have been cared for in non-Federal institutions under contract with the Public Health Service.

The Lancaster County Medical Society celebrated its 106th anniversary in April by inviting members of surrounding county medical societies and presenting a special program: "Recent Advances in the Management of Arthritis," by Russell Cecil, M.D., of Cornell University; "Recent Advances in the Management of Pulmonary Tuberculosis, and Notes on Post-sanatorium Care," by John N. Hayes, M.D., of Saranac Lake, N. Y.; "Management of Acute Respiratory Infections," by Hobart A. Reimann, M.D., of Jefferson Medical College.

TENDON INJURIES

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PROPER care of a severed tendon in the wrist or hand requires keen judgment and is a severe test of the surgeon's technique. When such a case presents itself for treatment, a decision must be made as to whether primary suture or secondary repair is indicated. The amount of time which has elapsed since injury, the mechanism of injury, and the nature of the first aid are important considerations. Primary suture of the tendon may be carried out if the time since injury is not greater than four hours, if the wound is a clean-cut one made by a sharp instrument, if the wound was immediately covered by sterile dressings, and provided no one has attempted to probe it or clamp a "bleeder." When the injury is in the distal palm or the proximal or middle segments of the finger, the time limit is one to two hours—preferably one hour. If the above conditions cannot be met, the proper procedure consists of excision of the wound and closure, with tendon or nerve repair delayed three to four weeks. If the wound becomes infected, three to six months must pass before secondary repair can be done.

Limited time prevents a detailed description of the technique. It should be emphasized, however, that this type of surgery cannot be properly done in the office or the hospital emergency room. It cannot be properly done by interns or residents early in their training period. Local infiltration anesthesia is contraindicated. Anesthesia should be accomplished either by regional nerve block or, if the repair is extensive, general anesthesia.

Tendon surgery to be successful demands greater attention to details in technique and mechanical principles than does general surgery. The usual amount of asepsis and the usual amount of surgical trauma incident to abdominal surgery will not produce satisfactory results. Our aim is to produce as nearly as possible a reactionless healing. Grasping tendons or sheaths with tissue forceps or sponging them with gauze

will sufficiently damage the endothelial coverings as to produce tissue reaction resulting in adhesions and scar. Tremor in the operator's hands should be reduced to a minimum by bracing the hands. Retraction should be gentle and immobile. This delicate work must be carried out in a bloodless field. A blood pressure cuff is applied to the upper arm and the extremity is elevated for one minute, following which the pressure is inflated to 280 mm. of Hg. and maintained at that level. Koch, Mason, and Allen state that this pressure may be maintained as long as necessary to complete the operation and apply the proper compression dressing and splint. They have found no evidence of constrictor paralysis even though the cuff was inflated for one to two hours prior to the preliminary release to catch bleeders and for a further two to three hours before it was finally removed.

If additional incisions are necessary to locate the ends of severed tendons, they are made on the mid-lateral sides of the fingers, parallel to the flexion creases in the palm and transverse at the wrist or in the forearm. Never should an existing wound be enlarged at its mid-point to produce a cruciate or a "T" type of wound. Never should an existing wound in a finger be enlarged in the mid-anterior line or across a flexion crease.

Deep wounds at the wrist usually produce multiple flexor tendon lacerations as well as nerve injuries. This type of injury, although time-consuming to repair, yields a high percentage of satisfactory results. Silk with a breaking strength of five pounds is the suture material of choice. Nerves are repaired with a neurilemma to neurilemma suture of No. 40 tantalum wire. Fascial structures are repaired and the skin closed with silk.

Severed flexor tendons in the palm proximal to the metacarpal heads likewise should yield results that are satisfactory when repaired by primary suture. If both the *sublimus* and *profundus* tendons are lacerated, the *lumbrical* muscle should be placed, and tacked by a few fine su-

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tures, between the tendon suture lines to prevent them from adhering one to the other. Either silk as a permanent suture or No. 34 or No. 35 stainless steel wire used in the removable suture technique of Bunnell is satisfactory. I prefer the latter, details of which are omitted because of a lack of time.

Flexor tendons are most frequently lacerated in the distal inch of the palm and proximal phalanx of the finger. Here the results by primary suture are poorest. In this region there is an annular band over the head of the metacarpal, another in the midportion of the proximal phalanx, and still another in the middle phalanx, forming a firm fibrous tunnel through which the tendons must glide, and whose purpose is to keep the tendons in their bed as the finger flexes. According to Bunnell, if the sublimus alone is cut in this area, it need not be repaired. If both tendons are lacerated, the sublimus should be sacrificed and cut short in the palm where it cannot adhere to the tunnel and prevent motion. The distal end should not be cut too close to its insertion, as this will cause the middle joint to hyperextend.

The action of the sublimus is to provide muscle balance to the finger and produce the final tight clinching motion as the fingers are flexed into the palm. The profundus tendon is essential for good function and must be repaired. Primary repair here should be done only under the most favorable circumstances. If it is decided upon, I feel that the "suturing at a distance" technique of Bunnell offers the most likelihood of success. Briefly, his method consists of placing a removable wire suture in the profundus tendon in the palm and anchoring it so as to hold the muscle under tension. Then the two ends of the profundus tendon, free from tension, may be united in the tunnel with one double right angle suture of the finest blood vessel silk merely to hold them in apposition. The annular band in the region of the suture line is divided laterally to allow for swelling of the tendon during healing. Mason and Koch, who use a silk technique, suggest that the annular band be excised entirely to allow the suture line to come into contact with the subcutaneous fat to reduce the likelihood of adhesions. Frequently, digital nerves are lacerated in this type of injury. They should be sought out and repaired; the result is usually good, with return of sensation in three or four months.

Proper splinting and after-care are as impor-

tant as the operation itself. Following the repair of any flexor tendon, a moulded plaster splint is applied to the dorsum of the forearm and hand with the wrist in almost complete flexion. A compression dressing is applied to the hand to prevent exudation and hematoma formation. Although it is a rather common belief among surgeons that early motion will prevent adhesions of tendons, this has been proved wrong by the experimental work of Mason and Allen. A brief summary of their findings is as follows:

1. Functional activity prior to the fifteenth day does not increase but weakens the healing tendon, provokes considerable tissue reaction, and causes the tendon to firmly attach itself to surrounding tissue.

2. From the fifteenth to the twenty-first day both mobilized and immobilized tendon increase in strength.

3. Beyond the twenty-first day immobilized tendon does not increase in strength.

This work forms the basis for physiologic after-care. The splint is not disturbed for three weeks. At that time the removable wire suture is removed if such technique was used. At this time the amount of flexion at the wrist can be decreased allowing a little more motion, although some protection is still necessary. After the fourth week the danger of breaking is over and movements of gradually increasing force are started. The patient must be instructed as to the proper method of exercise, i.e., holding the mid-joint of a finger while flexing the distal joint, holding the proximal joint while flexing the mid-joint, etc. A small block of wood is useful to use as a fulcrum to flex the joints individually. A rubber ball is not good because it encourages only flexion at the metacarpophalangeal joint. There is no type of physiotherapy which can replace a patient's own voluntary exercise after he is properly instructed.

Conclusions

1. Tendon surgery requires a more rigid atraumatic and aseptic technique than does general surgery.

2. Primary suture of tendons will give a better result than secondary repair. However, primary repair that has failed makes secondary repair more difficult and makes the prognosis less favorable.

3. Permitting motion prior to the fifteenth day weakens the healing tendon and provokes tissue reaction, resulting in binding adhesions.

Chronic Urethro-trigonitis in the Female

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CHRONIC urethro-trigonitis in the female is an exceedingly common disorder, yet infrequently recognized as a definite clinical entity meriting careful diagnosis and active treatment. Carson¹ stated that the urethra is responsible partially, or entirely, in 75 per cent of female patients complaining of urinary disturbances. Every urologist will attest this statement.

The female urethra is a short, membranous channel measuring 2.5 to 4 cm. in length, and corresponds embryologically to that portion of the male urethra located between the vesicle neck and colliculus seminalis. It is readily distensible, having an average diameter of 8 mm. The distal two-thirds of the structure is lined with stratified squamous epithelium transforming to transitional epithelium in the proximal third. The surrounding musculature, including the internal and external sphincter, makes the entire organ sphincteric in action.

All investigators are in agreement that the urethra contains, in addition to Skene's glands, numerous tubular and compound tubular glands which bear a specific relationship to the clinical entity under discussion, for it is within these that the original histopathologic changes occur. In spite of extensive research into the pathology of the female urethra, not all investigators agree that it contains glands which are homologous to the male prostate. However, the evidence presented tends to favor the work of Virchow,² Renner, Folsom,⁴ Beneventi, Powell,⁵ and others that the structural characteristics of the glands found in the proximal third of the female urethra are identical with those of the male prostate, and as such are subject to non-specific infections, and other analogous pathologic changes.

Incidence and Etiology

Urethro-trigonitis has its greatest incidence in the married multiparous female between the ages

of 30 and 50. The position of the female urethra with its frequent subjection to trauma and infection must, therefore, play an important role. Outstanding causative factors to be considered include:

1. Trauma incidental to parturition, coitus, masturbation, catheterization, instrumentation, and abdominal and pelvic surgery.
2. Pelvic infections of an acute or chronic nature, including *Trichomonas vaginalis* infection. The latter occasionally produces a rather severe form of chronic urethritis.
3. Chemical irritation secondary to douche or contraceptive medication.
4. A less common group including x-ray and radium reaction, allergic manifestations, and as emphasized by Hunner, distant foci of infection.

Histopathologic changes within the urethra occur early in life, as attested by the frequent occurrence of pyelitis in the female child without demonstrable pathology in the upper part of the urinary tract. The condition is attributed to repeated bouts of acute urethritis and cystitis, with the infected glands acting as foci for ascending infection to the upper part of the urinary tract by way of the lymph channels, as demonstrated by Van Duzen, Kretschmer,⁶ and Hanley.⁷ It is not uncommon for a young unmarried female to present herself in your office with the symptoms of urethro-trigonitis who under proper questioning will admit to masturbation or chronic sexual dissatisfaction. The importance of this type of congestive trauma was brought out by Friedman.⁸

There can be no more distressed person than the young female who on her wedding night presents the symptoms of an acute urethro-trigonitis, frequently referred to as "honeymoon cystitis." Undoubtedly the etiologic factor was lying dormant in the urethral glands with an acute exacerbation incident to the trauma of coitus. During the war years we could always

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predict a certain young soldier being home on furlough by seeing his wife in the clinic with acute symptoms, on one occasion within a few hours after his return. She came to live in dread of these visits, yet it was only then that we could stress the importance of adequate treatment.

I have little doubt that the use of certain contraceptive measures, namely, the diaphragm and vaginal medication, plays a small, but important, role in the entity under discussion. It is not unusual for a married female to date the onset of her symptoms to the beginning use of the above. Admittedly, a dormant infection may have been present, but the trauma of the diaphragm from pressing the urethra against the symphysis, along with chemical irritation of the medicament, are definite added factors. The role that the other factors play is self-evident.

The common organisms identified in urethro-trigonitis are the Staphylococcus, Streptococcus, and Colon group. However, it is not uncommon in the chronic form to find sterile urine on culture.

Symptoms

Chronic urethro-trigonitis is manifested in the female by a definite train of symptoms. Frequency of urination is, in our observation, the most common. This may vary from some slight frequency in voiding on first arising in the morning to severe frequency of every one-half to one hour both day and night. Varying degrees of dysuria, either initial or terminal, rank second, while burning occurs less frequently. Urgency is fairly common, and in a small percentage of cases is severe enough to be termed "urgency to the point of incontinence." Hematuria occurs in as many as 20 per cent of the cases, and again in varying degrees from a small amount initially, or a terminal drop or two noted on the tissue or clothing, to total gross hematuria.

Pain is a frequent accompaniment of chronic urethro-trigonitis and led Folsom⁴ to make the statement that "any pain within two feet of the urethra unaccounted for by other findings should be suspected of being due to the urethra." Most commonly, pain is referred to the suprapubic area, or low back, but any pain pattern may be present even to simulated attacks of acute ureteral or renal colic. Dyspareunia occurs in about 10 per cent of the cases.

The objective findings in the chronic cases vary, with tenderness and induration of the urethra the most positive finding. The urine is generally grossly clear, and in about 20 to 40 per

cent of the cases will be sterile on culture. This alone has led many a suffering female to be classified as "neurotic," "bladder conscious," or even "psychotic." Many are the women, therefore, who have used up boxes of barbiturates, who have made the rounds of all available physicians for relief, and not infrequently have gone through prolonged seances with psychiatrists, while a careful urologic study with a few simple treatments would have restored them to normal health.

The acute phase of the condition or the acute exacerbation of the chronic urethro-trigonitis is manifested by alarmingly severe symptoms of frequency, urgency, strangury, terminal pain, constant uncontrollable desire to void to the point of incontinence, suprapubic, inguinal, and low back pain. Not infrequently, general symptoms of malaise, chills, fever, nausea, and vomiting are present, while the urine shows the presence of pus and blood, with the micro-organisms listed above being demonstrated on culture.

Pathology and Diagnosis

With a study of the gross pathologic changes present, the diagnosis becomes obvious. The primary pathologic change lies in the mucosal and submucosal layers of the urethra and trigone, with the altered anatomy easily visible on cysto-urethroscopic inspection. Again, the findings vary with the chronicity of the condition and the frequency with which acute exacerbations have occurred.

In the early stage the visible findings consist of increased vascularity of the mucosa of the urethra and trigone, along with a diffuse redness and some edema. Not infrequently, even at this point, will the trigone be covered by a thin white pseudomembrane, the so-called "pseudomembranous trigonitis." The pathologic picture in the advanced chronic stage is more pronounced. On inspection, the external meatus may appear tightly closed with a cartwheel appearance, or reddened hypertrophied mucosa may present itself with varying degrees of prolapse. On palpation, the urethra will be tender and thickened. The cystoscope often fits tightly, either because of a localized stricture at the external meatus or a generalized constriction of the urethra. On panendoscopic inspection, there may be mucosal proliferation with a diffuse redness and granular appearance. Superficial ulcerations are common, along with increased vascularity, with resultant bleeding from the surface on slight manipulation

of the instrument. Varying degrees of edema will be present, giving the internal vesicle orifice a "scalloped" appearance. Polypoid formations occur at the internal orifice along with vascular papillary projections. These changes extend over to involve the trigone, which becomes hypertrophic, shortened, and edematous, with either a hemorrhagic, granular, pseudomembranous, or cystic appearance. The bladder mucosa beyond the trigone is usually normal.

In the acute stage, or during an acute exacerbation, the findings are those of above, with the added increased vascularity, redness, and edema that accompany any acute infection. Involvement of the remainder of the bladder may be present up to the acute ulcerative or hemorrhagic types of cystitis. From the pathologic changes occurring in the urethra, as noted above, it is obvious that Twinam's statement that "the urethra is only the resting place for the cystoscope in investigating the bladder" is far from true. The diagnosis is easily made in any patient who presents the above history and physical findings correlated with the changes observed on cystoscopy. Failure in making the diagnosis is entirely an oversight by the examining cystoscopist.

Since certain pathologic conditions may be present in the upper part of the urinary tract as a part of or in association with urethro-trigonitis, investigation by ureteral catheterization, retrograde pyelography, and differential cultural studies, are a must in every case.

In the differential diagnosis, after ruling out changes in the upper part of the urinary tract, the following conditions are to be considered: (1) abscess of Skene's glands, (2) purulent urethritis of a specific nature, (3) sub- or peri-urethral abscess, (4) urethral diverticulum, (5) urethral stricture, (6) true urethral caruncle, (7) foreign body or neoplasm of the bladder, (8) neurogenic bladder, (9) tuberculosis, (10) chronic interstitial cystitis with Hunner's ulcer, (11) urethral tumor.

A careful history with correlation of the physical examination and cystoscopic findings will always provide the diagnosis, and where tumor is suspected, biopsy should always be performed.

Treatment

Once the diagnosis of urethro-trigonitis is made, the treatment resolves itself into a few simple procedures which can be easily carried out in any physician's office. In our clinic we have used the following plan of treatment, with

resultant, early, and complete relief of symptoms, and consequently, the gratification of many patients.

The first step to be considered is that of urethral dilatations which can be accomplished by either curved male or straight female metal sounds, or even silk woven bougies. This procedure is carried out at five to seven-day intervals at the onset of treatment, with the interval gradually lengthened as improvement is noted. Dilatation as to caliber should be gradual until the urethra accepts a No. 32 French sound with ease.

Bladder irrigation and occasionally bladder distention are carried out next through the use of a soft rubber catheter. The mildly antiseptic solution we commonly use is 1:8000 potassium permanganate, but a mild boric acid or sulfonamide solution will serve the purpose just as well. Bladder distention is not commonly practiced, because in the large majority of cases the bladder capacity is normal.

Following lavage, the final step in local treatment consists of the instillation of a mild silver nitrate preparation, beginning with one ounce of 1:1000 silver nitrate and gradually increasing the strength used up to $\frac{1}{2}$ to 1 per cent. We have found the use of stronger solutions not necessary, while occasionally protargol, argyrol, or cajandol is preferable in the more severe cases at the onset of treatment.

We have reserved fulguration by electrocautery of the polypoid areas at the vesicle neck for the patients who do not respond to the above plan of therapy. We have, therefore, used it very infrequently, but in those in whom it had been used definite relief of symptoms was prompt and actual.

Additional measures stressed are the use of a daily hot sitz bath or warm vaginal douches. Avoidance of foods which the patient herself has found to aggravate her symptoms is recommended, and in all cases the use of alcohol and heavily spiced or seasoned foods is eliminated.

For the relief of symptoms while local treatment is in progress, certain of the dye preparations such as methylene blue, pyridium, serenium, etc., in conjunction with an alkalinizing, antispasmodic, and sedative mixture as below, are very beneficial.

Treatment of the acute case, or acute exacerbation, further entails the use of the various chemotherapeutic or antibiotic agents. I should like to add that the use of small doses of one of

RX—CYSTITIS MIXTURE

Potassium acetate
 Strontium bromide aa..... 1 oz.
 Tinct. belladonna ½ oz.
 Tinct. hyoscyamus 1½ oz.
 Aqua q.s.ad 6 oz.
 (Filter)
 SIG: One teaspoonful two or three times daily.

the sulfa preparations, preferably sulfathiazole, ½ gram every four to six hours, is often just as beneficial in the treatment of the acute form of urethro-trigonitis, and certainly less expensive to the patient than the use of some of the more recent antibiotics.

Review of Cases

Fifty consecutive cases in which the diagnosis of urethro-trigonitis was made during the year 1948 were studied. All were treated entirely in the urologic outpatient department. Of the fifty, 40 were married, with 27 of this group having one to five children. The youngest patient treated was 16 years of age, the oldest being 71, while the over-all average age was 46 years. Six of the 50 cases were first seen during the acute phase.

The outstanding symptom of all was diurnal frequency, with dysuria, suprapubic discomfort, burning, and urgency next in occurrence. Seven of the patients complained of urgency to the point of incontinence, while 11 cases had varying degrees of hematuria. Four of this latter group had their symptoms initiated by an attack of an associated acute hemorrhagic cystitis. Two cases had retention of urine, with difficulty in urination complained of by eight. Four patients admitted to dyspareunia, while 19 of the group had pain referred to the costovertebral angle simulating ureteral colic at some time during the course of their illness. It is impossible for me to quote figures, but I am sure that several of the group underwent lower abdominal surgery because of referred pain. The duration of the symptoms ranged from one week up to fifteen years.

On physical examination, 10 cases actually presented costovertebral angle tenderness, with pelvic examination showing definite endocervicitis in six. Practically all the patients complained of urethral tenderness, while 18 were found to have a thickened, indurated urethra.

The examination of each case, in addition to the history and physical examination, included complete endoscopy, bilateral ureteral catheter-

ization, retrograde pyelography, a routine urinalysis, and differential urine cultures.

In only 6 cases did the urine show microscopic pyuria, while in only 8 cases were completely sterile urines obtained on culture. In the group with positive cultures, the *Staphylococcus aureus* was by far the most common organism, occurring in 27 cases, with *Escherichia coli* in eight, *Streptococcus hemolyticus* in four, and *Aerobacter aerogenes* in three.

The occurrence of ureteral stricture was nil, and pyelograms were normal in 46 cases, with 3 cases presenting double kidneys and partial reduplication of the ureter, and the remaining case showed bilateral hydronephrosis and hydro-ureter. In the latter case, sphincterotomy had to be carried out as part of the treatment to relieve severe obstruction of the lower part of the urinary tract.

On endoscopy 22 cases showed urethral stenosis or stricture, with 20 cases showing definite polypoid or papillary projections at the vesicle orifice. The trigonal appearance in the series showed 35 cases of the granular type, 9 pseudomembranous, 4 hemorrhagic, and 2 cystic.

All received treatment as discussed above except for the 6 cases seen during the acute phase, and in those the treatment was supplemented by urinary tract antiseptics, either mandelamine, sulfonamides, penicillin, or streptomycin. Each patient was distinctly better after two to three treatments. Recurrences did occur in a few, but promptly disappeared on continued treatment. No fulgurations were required by this group, all having responded to the above plan of treatment. It is our policy to follow patients at progressively longer intervals up to three months to determine any regression.

Summary

1. Chronic urethro-trigonitis is a common affection of multiparous females between the ages of 30 and 50.
2. The condition has its origin with infection in and about the urethral glands, producing definite histopathologic changes, a definite train of symptoms, and objective findings.
3. The diagnosis is made by cysto-urethroscopic examination.
4. Treatment can be carried out in any physician's office, entailing a few simple procedures.
5. Finally, the female patient who complains bitterly of bladder symptoms with a negative urine is not neurotic, but is suffering from

chronic urethro-trigonitis, a definite clinical entity.

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READ YOUR POLICY

If a glib fellow came to your door and tried to sell you what he described as a medical and hospital insurance policy covering all expenses which you or any member of your household might incur in event of illness, you would be highly interested. If you examined the policy a little more closely and discovered that it did not cover all persons in your household, but only those meeting certain tricky "eligibility" tests, you would begin to distrust the man. If he then waved hospital bills for fabulous sums under your nose and asked if you didn't want to be protected against all such expenses, you would look again at the policy he was trying to sell you. And then, if you discovered that his hospital policy would reimburse you only to the extent of the minimum charge for ward accommodations, you would reach for the telephone to notify the legitimate insurance underwriters and other proper authorities.

That is precisely the sort of phony sales talk which Truman Administration spokesmen are giving the American people. As pointed out by Dr. Elmer Hess of Erie, Pa., vice-chairman of the Council of Medical Practice and chairman of the Hospital Practice Council, American Medical Association, in Buffalo the night before last, the much-debated Title Seven of the pending National Health Insurance and Public Welfare Act is not an insurance plan at all, but a tax scheme. It is a proposal to impose a payroll tax on all employed Americans and their employers and to use the money raised by such taxes to make contributions toward paying medical and hospital expenses of some of the persons paying the taxes. We say "some of the persons" because many millions of veterans of World War I and World War II would be paying 1½ per cent of their wages and salaries for "insurance" which wouldn't insure them—as they already are entitled to Veterans Administration medical and hospital care without charge.

So the pending health insurance measure would force 16 or 17 million veterans to pay hundreds of millions of dollars for "insurance" without due benefits in return—and would deny insurance to the countless poor persons who would need it most, unless their taxes were paid for them. Proponents of the bill talk much about the admittedly staggering cost of chronic illness to American families, but carefully avoid mentioning the fact

that the bill excludes from its benefits sufferers from tuberculosis and all other chronic diseases.

Dr. Hess did a masterly job of exposing the manner in which the sponsors of the Federal health insurance bill are trying to delude the people of the United States. His opponent in the debate here, Hugh Thompson, regional director of the CIO, cleverly avoided debate on the actual text of the bill and devoted most of his time to vilifying the American medical profession.

American physicians, Mr. Thompson contended, are interested only in the "dollar sign." In America today, Mr. Thompson said: "If you have the money to pay for medical care, you get it. If you don't, you don't." American doctors are in a conspiracy against their own patients to perpetuate a system of private medical care which is "slowly eating away the vitality of the nation"—according to Mr. Thompson.

Edmund Burke said that he knew no way of drawing up a bill of indictment against a whole people, but Mr. Thompson thinks he knows how to draw one against a whole profession. Because of their long experience with the ills to which mortal flesh is heir, most physicians and surgeons are amazingly tolerant persons. This was made manifest the night before last when Erie County doctors listened patiently and courteously while Mr. Thompson traduced their profession.

The average American judges physicians and surgeons by his or her own experience. In a vast majority of cases that experience is such as to win for the medical profession a place in public esteem comparable to that held by the clergy. Naturally, most Americans resent mean and despicable slanders directed against men whose lives are consecrated to saving the lives of others.—Editorial, *Buffalo Evening News*, April 5, 1950.

The AMA defines a "resident physician as one who is in hospital training for a specialty or for general practice and who has been out of medical school not more than five years."

The subscription rate of the *AMA Journal* for resident physicians is \$9.00 per annum, the same as is granted to students and interns.

Present Ideas Concerning Body Fluids and the Chief Electrolytes

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THE SIGNIFICANCE of water in the composition of the body can perhaps be best emphasized by pointing out that the human organism can more logically be considered a solution rather than a solid. Certainly this view receives ample quantitative support from the demonstration that in health as much as 70 per cent of the body weight is made up of water.^{1, 2, 3} It is immediately obvious, therefore, that significant alterations in this preponderant portion of the human organism, or of the solutes dissolved in it, might well be associated with changes in body function. That these can indeed be profound, and even jeopardize the survival of the individual organism, is the gist and the substance of this discussion.

The Physiologic Effects of Body Water Losses. It is amply clear, for example, that complete deprivation of obvious fluids from the intake of most experimental or clinical subjects will soon result in death.^{4, 5, 6} The length of survival varies with the particular species studied, and depends on the ability of the subject to conserve body water under these circumstances. This capacity is directly related in turn to the ability of the kidneys to elaborate a concentrated urine. Thus the desert rat, with perhaps an indefinite survival period on solids alone, can excrete a urine of such high specific gravity that the water produced during the metabolism of foodstuffs provides an adequate daily supply.⁷ In terms of water conservation other species such as the desert burro, dog, and man are considerably less efficient, and hence cannot survive on the water of metabolism as the sole source of fluid.⁸ As an important corollary it should be pointed out that with diminishing surface area the per kilogram water requirements rise. It is obvious, therefore, that the limited capacity of man to survive under adverse conditions of water supplies will be accentuated in infants.⁹

What physiologic changes accompany and perhaps account for these limited periods of survival? First, it is almost unnecessary to emphasize that chemical or biochemical reactions occur slowly, if at all, when the reagents are present in solid form. It is logical to suppose, therefore, that a dehydrated cell has lost some functional capacity as its water content declines from the optimal. As a matter of fact, evidence is available which illustrates clearly that this is a fact. For example, simple dehydration is frequently but not invariably accompanied by deterioration of circulatory efficiency. In a significant proportion of experimental situations characterized by simple water dehydration, the blood pressure drops, the circulation time is prolonged, and the blood pressure and cardiac output fall.^{10, 11} It is not unreasonable to suggest that a similar impairment of cardiovascular efficiency occurs frequently in human dehydration, though it may be of insufficient degree to be detectable by clinical observations alone. The routes of water loss in any patient which may produce dehydration can be summarized as follows:

	cc./24 hrs.
Losses of body water in urine	350-1500
Insensible loss through skin and lungs	600-1400
Visible perspiration	0-3000
Water losses in vomitus, drainage, exudate, diarrhea, etc.	0-2000+

It is immediately obvious that to maintain body stores of water intact a patient will need at least 950 cc. of fluid daily, and may require as much as 8 liters per day! This must be supplied in either the intake or the input, since the water derived from the metabolism of endogenous or exogenous carbohydrate, protein, or fat¹² will not even begin to replace the daily losses. It should be further stated, however, that it is advantageous to avoid protein foods whenever water supplies are limited, since urea, the nitrogenous end-product, may pre-empt a certain vol-

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ume of water which otherwise would not have been lost.¹³

In a certain sense simple dehydration is one of the lesser evils which attend incomplete replacement therapy during illness. To illustrate this point clearly, it is first necessary to indicate that the fluid of the body is present in compartments, which differ in volume and in composition.¹⁴ Thus, of the 65 per cent or so of the body weight present as water, 40 or more of the 65 per cent consists of water in cells, and hence is referred to as the cellular or intracellular phase. The remainder is made up of water outside of cells and therefore is designated as extracellular fluid. This in turn consists of interstitial and plasma fractions, present normally in the ratio of approximately 4:1. In simple dehydration, losses of body water are shared in various proportions by these subdivisions.^{13, 15} As a consequence the physiologic significance of the water deficit is minimized, since the change in the size and composition of any one compartment is small. This applies particularly to the earlier phases of dehydration; however, it has already been pointed out that, if sufficiently protracted, water deprivation will prove fatal.

Changes Accompanying Losses of Extracellular Electrolytes. A somewhat different sequence is observed when excessive amounts of the chief extracellular electrolytes, sodium and chloride, are lost. If these deficits of electrolytes are proportionately greater than the losses of water, the extracellular fluid becomes hypotonic. Under these circumstances water leaves the interstitial phase and moves into the cells. It is clear therefore that in this situation the dehydration is not distributed through the two phases. Actually the deficits of body water are borne solely by the extracellular compartment and by the plasma in particular. As a consequence the hematocrit and serum viscosity both rise, the circulation time is prolonged, and the cardiac output and blood pressure fall. These changes indicate that circulatory collapse is the physiologic sequel of predominant losses of extracellular electrolyte.¹⁵ This shock state from the point of view of the organism's survival presents the same hazards as those encountered following trauma, burns, or massive hemorrhage. It may develop in the course of gastro-intestinal fluid losses, in diabetic acidosis, in adrenal insufficiency, and in some instances of renal disease. Actually it can be present in unrecognized form in a wide variety of unrelated clinical disorders during which

deficits of extracellular electrolytes have developed. Treatment must obviously consist of adequate replacement of the salt and water deficits; it may have to be supplemented in some instances by the administration of plasma or blood.¹⁶

Conditions in Which Extracellular Constituents Are Present in Excess. It cannot be denied that under certain circumstances an excessive supply of the chief extracellular electrolytes may also prove harmful. The administration of hypertonic saline or the ingestion and retention of sea water can, for example, produce hypertonicity and dehydrate the cells. The nervous system appears to be particularly sensitive to such changes, since death from respiratory failure often ensues.¹⁷ It has also been recognized that the administration of even small amounts of saline to certain patients with vascular disease may be harmful. Individuals ill with acute glomerulonephritis, toxemia of pregnancy, or intensive arteriolar disease are especially prone to develop circulatory failure, pulmonary edema, or aggravation of the underlying disorder.¹⁸ Finally, it is generally understood that even less than the usual intake of sodium will produce edema in subjects with hypoproteinemia, renal or heart disease.

The increasing realization of the occurrence of excessive tubular reabsorption of sodium in patients in the last category should be emphasized, since it has turned our attention to factors other than the heart itself in producing edema of congestive failure. It must also be pointed out that in infants otherwise well but who have not as yet attained full renal function⁹ moderate amounts of saline may produce the changes observed in adults who are ill or in whom saline administration has been excessive. These facts have led some clinicians to avoid the use of saline entirely in correcting dehydration. This stand may, it is true, prevent the occurrence of some of the complications which have just been described. If this is practiced as a universal policy, however, an equal and even larger number of patients will suffer from inadequate replacement of much needed salt stores.

Changes Accompanying Alteration in Extracellular and Cellular Potassium. A clearer understanding should also now prevail concerning the role of potassium in various disease states. This ion is one of the chief electrolytes in cells and is ordinarily present in much lower concen-

trations in the extracellular fluid. Certain physiologic adjustments serve to maintain serum and extracellular fluid concentrations of potassium in health within a normal range of 3.5 to 5.5 milliequivalents per liter. In some but not all cases of renal failure, in patients with adrenal insufficiency or with too rapid administration of potassium salts, the upper limits will be surpassed.^{19, 20, 21} These abnormal concentrations of serum and extracellular potassium, if sufficiently high, produce characteristic electrocardiographic changes.²² The first of these consists of peaked T waves; progressively the P waves may then be lost, to be followed by intraventricular block, asystole, and death. On the other hand, abnormally low concentrations of potassium in interstitial fluid and plasma are at times associated with paralysis of the voluntary muscles. Frequently it is also possible to demonstrate abnormalities of the S-T segment and T waves of the electrocardiogram. Both of these have been described in familial periodic paralysis and in potassium deficiency states.^{23, 24}

Insofar as cell potassium is concerned, no syndrome or harmful effect has been identified to date with increases in this fraction. Such increases do occur, however, in the course of potassium administration, adrenal insufficiency, and a host of physiologic processes characterized by transfers of this electrolyte into cells.²⁵ On the other hand, decreases in cell potassium may be of profound physiologic significance. The experimental production of such a deficiency is associated, for example, with necrosis of the myocardial fibrils.²⁶ Clinically, too, it has been shown that replacement of potassium deficits decreases the mortality among infants ill with diarrhea.²⁷ A similar retention of administered potassium pointing to the existence of cell deficits of this cation has been observed in adults and infants with gastro-intestinal disorders,^{28, 29} and in diabetic subjects undergoing treatment for acidosis and coma.²¹ It appears likely that deficiencies of cell potassium occur far more frequently than has been hitherto suspected, and that they may serve to explain unexpected fatalities in patients in whom therapy has been considered adequate by current standards.

Summary and Conclusions

The importance of alterations in the composition of the body fluids in influencing physiologic processes has been discussed. Analogies have been drawn relating experimental findings to

clinical problems arising from dehydration and certain electrolyte disturbances.

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CARCINOMA OF THE BREAST

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THOSE of us who have the opportunity of examining several hopelessly inoperable cases of carcinoma of the breast during a year at times wonder whether our efforts at lay education on cancer are bearing fruit and whether the public understands the importance of periodic examinations and of consulting their physicians immediately should a lump be discovered or any untoward symptoms develop. Our own distinguished member, the late Dr. Jonathan Wainwright, was the pioneer in cancer education.

The laity realizes, as never before, the dangers of a lump in the breast and there is an increasing number of women who come with painful breasts, with small lumps, and those who wish to be assured that they harbor no pathology in their breasts.

We have made a careful study of our cases to determine the length of time which elapsed between the discovery of the tumor and the surgical consultation and to ascertain the percentage who came within one year, six months, and one month.

We have divided our cases into two twelve-year periods, one eight-year period, and one five-year period. The figures are interesting and prove without a doubt that our cases are coming much earlier; the length of time which elapsed between the discovery of the tumor and our examination has steadily decreased, also the number coming within a month has decidedly increased. For example, in the first twelve-year period, from 1910 to 1922, *sixty-five* weeks elapsed before surgical consultation:

43.3% came within six to twelve months
31.4% came within one to six months, and but
7.2% came within one month or less

In the second twelve-year period, *fifty-five* weeks elapsed between the discovery of the tumor and our consultation:

55.5% came within six months to one year
40.4% came within one month to six months
23.2% came within less than one month

In the eight-year period a greater improvement is shown. The time which elapsed between the discovery of the lumps and our examination dropped to 33.6 weeks:

38.6% came within six months to one year
36.4% came within one month to six months
25 % came within less than one month

Four cases in this series came for examination the day the tumor was discovered.

The five-year period from 1944 to 1949 showed even a decided improvement upon the eight-year period, because only 18.7 weeks elapsed from the discovery of the tumor to our examination:

8.2% came within six months to one year
39.7% came within one month to six months
37.6% came within less than one month

AVERAGE DURATION OF DISEASE FROM FIRST SYMPTOM TO TIME OF OPERATION

	1910	1923	1935	1944
Months	1922	1934	1943	1949
6-12	43.3%	55.5%	38.6%	8.2%
1-6	31.4%	40.4%	36.4%	39.7%
0-1	7.2%	23.2%	25.0%	37.6%

Reports from all surgical clinics show a marked increase in the ten-year survival rates between those patients who have no axillary involvement at the time of operation and those who have axillary involvement. In other words, carcinoma of the breast with axillary involvement is a very different problem from carcinoma of the breast without axillary involvement.

In following 409 of our cases carefully at the Guthrie Clinic, we found these results:

Without Axillary Involvement

Living 5 years 65.5%
Living 10 years 40.9%

With Axillary Involvement

Living 5 years 23.0%
Living 10 years 9.8%

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From the Surgical Department of the Guthrie Clinic, Sayre, Pa.

Reports from other surgeons coincide with our experience.

Author	Nodes Not Involved, Living and Well	
	5 Years	10 Years
Harrington	63.6%	44.1%
Bunts	35.0%	18.0%
White	70.0%	57.0%
Guthrie	65.5%	40.9%

Author	Nodes Involved, Living and Well	
	5 Years	10 Years
Harrington	24.3%	13.4%
Bunts	20.0%	8.8%
White	19.0%	10.0%
Guthrie	23.0%	9.8%

Radiation Therapy for Carcinoma of the Breast

There is much controversy concerning the indication for radiation therapy in some situations, but it is safe to say that the addition of radiation therapy as an adjunct to the surgical treatment of breast cancer has resulted in an over-all improvement of 5 to 10 per cent in the five-year survival rate. Radiation has no place in the treatment of primarily operable carcinoma of the breast, but it does play a large part in the treatment of breast cancer with spread to the regional glands or where it has metastasized widely. In our hands, radiation therapy is employed post-operatively in only those patients with axillary involvement. In patients with late carcinoma with large foul sloughing lesions, preoperative radiation is frequently employed to get rid of the offensive lesion and permits clearing up the chest wall by doing a simple mastectomy. Radiation therapy in most instances is a palliative measure only, but occasional spectacular cures have resulted from intensive therapy where surgery has not been possible.

Hugh Trout first suggested the use of irradiation to ablate the menstrual period in patients with carcinoma of the breast who had not reached the climacteric. Horsley performed oophorectomy upon such patients. Most surgeons believe that cessation of the menstrual period increases the patients' chances of remaining well and many men employ irradiation, which we use in our clinic.

The use of androgens and estrogens has been employed besides roentgen therapy for the treatment of advanced mammary carcinoma. Adair recently reported on 105 patients with advanced carcinoma of the breast who received androgens and estrogens. Large doses of testosterone propionate were given to 70 patients with metastases to bone, soft tissue, or both. Objective improve-

ment occurred in 19 per cent of patients with skeletal metastases and 15 per cent with extra-skeletal metastases. The most impressive symptomatic effect was the relief of pain, which was temporarily effective in 44 of 58 patients, and it was a strange occurrence to have these patients improve symptomatically even though the disease progressed. This improvement extended over a period of from two to four months.

The side effects of androgen therapy in some of the patients were edema of the legs, deepening of the voice, hirsutism, increased libido, and acne. We had one patient among the six whom we treated with androgen therapy who showed such changes.

Adair treated 35 patients with estrogenic substances, 20 patients with diethylstilbestrol, 10 with ethinyl estradiol, 4 with estrone sulfate, and 1 with estradiol benzoate. There was symptomatic improvement in 23 per cent of the 35 patients with soft tissue involvement; in 11 of 18 patients pain was significantly relieved. One-fourth of these patients were unable to work or give themselves personal care. The improvement in most of them was such that they were able to carry on physical activity. Vaginal bleeding occurred in six of the 35 patients; nausea and vomiting persisted in nine. With more study and experimentation it is hoped that endocrine therapy will further benefit these unfortunate cases.

A very definite knowledge of the anatomy of the breast and the blood supply to the breast and the pectoral muscles facilitates performing a wide radical mastectomy with little trauma and a great reduction in the amount of blood lost.

The anatomy of the nipple and the lactiferous ducts, which contain malignant or benign papillomas producing a bloody discharge which terrifies the patient, must be well understood if the ingenious operation of Babcock is employed so as to know the exact location of the duct containing the papilloma. As most of these papillomas are benign, it is unwise to remove the breast unless the papilloma is malignant.

For many years we have employed the incision of Rodman with inspection and a primary sharp anatomic gentle dissection of the axillary contents, as first suggested by Willy Meyer. In our opinion this method has many advantages over the methods commonly employed of mobilizing the breast first through a racquet incision which extends well out upon the arm and dissecting the axillary contents after the breast has been mobilized. In the first place the scar is kept off the

arm, which permits immediate mobilization and free use of the arm, a factor which we believe prevents the development of that most unfortunate postoperative complication—lymphedema; it permits inspection of the axillary contents to determine the exact extent of metastasis.

Thirty of our patients were found to be inoperable because of the extent of axillary involvement—a fortunate thing to discover, because it contraindicated mastectomy; it permits severing and ligating the branches of the axillary artery which supply the pectoral muscles and the breast with blood. With good exposure, which is secured by dividing the tendons of the pectoralis major and minor and cutting the firm band of axillary fascia, a very complete and sharp anatomic dissection of the contents of the axillary space may be performed. The acromiothoracic artery and vein are clamped and severed at the apex of the space, the long thoracic or the lateral thoracic artery and vein (the short alar thoracic, if present), and finally the posterior thoracic or subscapularis artery and vein are clamped and ligated. It is very easy to recognize and protect the long thoracic nerve—the external respiratory nerve of Bell, which supplies the digitations of the serratus magnus muscle, and the thoracodorsal nerve which supplies the latissimus dorsi muscle. A winged scapula results if the long thoracic nerve is cut.

We believe that a low-grade infection of the axillary space is difficult to recognize postoperatively, that it is caused by unnecessarily rough dissection, and that it is a factor in the production of postoperative lymphedema of the arm.

The Rodman incision extends from one inch below the clavicle, two fingers' breadth inside the sulcus formed by the deltoid and the pectoralis major muscles. It extends downward over the anterior axillary fold and, after reflecting the skin edges, it is not difficult to sever the tendon of the pectoralis major at its insertion into the bicipital groove on the humerus and the tendon of the pectoralis minor from its insertion into the coracoid process of the scapula. After the contents of the axilla have been mobilized en masse, the breast is encircled by a long incision which extends down upon the abdomen and which permits the removal of the fascia of the recti muscles, as suggested by Handley. The inner part of the long incision for removal of the breast joins the mid-portion of the Rodman incision; the outer margin joins the outer end of the Rodman incision. After undermining the inner edge of

the breast incision by cutting the tissues on a slant, the origins of the pectoralis major muscle from the clavicle and the sternum are divided between several Ochsner clamps. By this maneuver the perforating branches of the internal mammary arteries, which are large vessels and supply the muscles and the breast, are severed. By this method the amount of blood lost in a radical mastectomy is greatly reduced. By the primary division of the branches of the axillary artery, already described, and by the immediate control of the branches of the internal mammary arteries, many of our patients who require the radical mastectomy lose far less blood than those upon whom we perform simple mastectomy.

The origins of the pectoralis minor from the ribs are clamped before severing them. This method prevents the retraction of the intercostal vessels which are very difficult to control if lost and is a safeguard against entering the pleural cavity, which we have seen occur. The outer edge of the incision is then widely undermined and the breast freely mobilized. A towel clip placed upon the nipple at the beginning of the operation permits moving the breast freely in any direction and lessens the danger of massaging the tumor during the dissection.

The breast with the fascia of the recti muscles, with the pectoral muscles, and with the contents of the axilla is removed as a single specimen.

All vessels are securely ligated with very fine No. 100 cotton ligatures. The skin edges are approximated with figure-of-eight crochet cotton sutures which we find are very much more comfortable for the patient than silkworm gut sutures because they do not cut through the skin and do not become adherent to the dressings. At points of greatest tension, we pie-crust the skin to allow for the immediate release of serum—in this way keeping many of our flaps viable. It is most unusual for us to employ drainage. Should a seroma develop, it is aspirated through a needle and the wound edges are never separated for drainage, a method which encourages infection.

We employ skin grafts in very few of our cases. We agree with Judd who believed that skin recurrences began in the fascia underneath and later involved the skin. We therefore practice wide removal of the fascia of all the muscles.

The primary dressing is important. A short soft commercial rubber sponge is placed in the axilla and a long sponge placed over the long incision. The dressings are held in place by a five-yard gauze roller bandage, fixed about the

abdomen and placed about the shoulder in a spica formation. This primary dressing is not disturbed for three days, but immediate mobilization of the arm is begun the day of the operation and continued and increased daily so that when the patient leaves the hospital she has perfect motion and can assume the "Statue of Liberty" pose.

By keeping the incision off the arm, by sharp anatomic dissection of the axillary space, which protects it against infection, by using a technique which makes drainage of our wounds unnecessary, and by our efforts to secure wide mobilization of the arm, we believe that we have protected our patients from that unfortunate, disabling complication of postoperative lymphedema of the arm.

In a review of a hundred consecutive breast cases operated upon in our clinic, we found that eight patients had a certain amount of edema of the arm. In six the edema entirely subsided by employing conservative measures; in two, definite and marked pitless edema developed. One has been operated upon with a satisfactory result, and the other patient decided not to follow our advice.

Five years ago we became interested in the subject of postoperative lymphedema and have used a method suggested by Beck of our clinic which offers relief to a certain number of well-chosen cases. We were surprised at that time to find that there were but thirteen articles published in the British and American literature which only mentioned the subject.

In selecting cases for the Beck operation, one must be absolutely sure that the edema is not due to metastasis. Cases showing marked fibrotic changes in the skin, in the axilla, and on the chest wall as a result of postoperative irradiation should be chosen with care and the patient should understand that this condition might militate against a good result. It is well to follow Veal's suggestion of employing venograms and not accept cases for operation which show marked obstruction in the axillary and subclavian veins.

Halsted first called attention to this unfortunate condition in 1921. He believed that infection in the axillary space was the cause of the block in the lymphatics and at times the veins. He was of the opinion that the infection may be so mild as to escape detection. Devenish and Jessop strongly challenge Veal's belief that the edema is due to venous obstruction and a rise in

venous pressure above 170 mm. which will allow fluids to escape into the tissues. They believe that lymphatic obstruction alone is sufficient to cause postoperative non-malignant swelling and the rise in venous pressure which occurs during exercise. To quote them: "While excision of all the lymphatics running from the breast to the axilla is essential, it might be possible to deliberately preserve some of the main lymphatic channels at the upper end of the arm. These main channels run in the fatty subcutaneous tissue and may be preserved if the subcutaneous tissue is left in the flaps."

The purpose of the Beck operation is to furnish a superficial lymphatic flow between the arm and the chest wall.

The new channels are formed by inserting celloidin strips from the arm to the chest wall. These are placed subcutaneously on top of the muscles. We use three strips anteriorly and three posteriorly. Through small incisions on the arm, the tissues are gently undermined by a long curved forceps until the desired point is reached in the chest anteriorly and over the scapula posteriorly. A small incision is made above the end of the forceps and the incision widened sufficiently until the celloidin strip may be drawn underneath the skin and out through the original incision. The end of the strip is then buried under the skin of the first incision. The arm is placed upon an aeroplane splint for three weeks. The strips are then removed under local anesthesia. Roller bandages and massage are then used to encourage the flow of lymph through these new channels.

Fortunately, this is a rare condition, but the patient suffers greatly. The involved arm is practically useless; there is great swelling of the hand and the arm, with a brawny change in the skin. The edema is pitless and many of these arms weigh several pounds more than the uninvolved member.

In a few patients acute lymphangitis will develop. The arm is mottled, very red and painful, and fever and chills are present.

We have greatly benefited 70 per cent of our patients who have been chosen for the operation, and we believe that with better judgment in not accepting those who have extensive fibrotic changes in the axilla resulting from postoperative irradiation and the employment of venograms, as suggested by Veal, our results will be even better. As the operation is a minor one and extremely safe, we recommend that it be employed.

PITUITARY DISORDERS IN CHILDHOOD

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THE PITUITARY gland is an endocrine structure situated in the sella turcica at the base of the skull. It consists of an anterior and a posterior lobe. The anterior lobe develops from a hollow outgrowth of the buccal epithelium and is composed of eosinophilic, basophilic, and chromophobe cells. The posterior lobe is derived from a downgrowth of the neural ectoderm of the third ventricle and consists of modified neuroglial cells.

Extracts from the anterior lobe have been shown to contain a growth hormone, a gonadotropic hormone, and also thyrotropic, adrenotropic, and lactogenic principles. Growth hormone is secreted by the eosinophilic cells, and gonadotropic hormone by the basophilic cells; the origin of the other endocrine factors is as yet undetermined. Evans and Long at the University of California in 1921 proved the role of the eosinophilic cells in secreting the growth hormone. A pure growth hormone was isolated by Freud of Amsterdam in 1938, although growth extracts as usually prepared contain adrenotropic and thyrotropic factors. The posterior lobe produces a substance called pituitrin which contains two fractions—pitressin, the anti-diuretic principle, and pitocin, which stimulates uterine contractions.

In 1910 Cushing performed a series of operations on the pituitary gland of dogs. He found that complete removal consistently brought about progressive weakness, drowsiness, anorexia, hypothermia, hypotension, coma, and eventual death in all cases within 21 days; this is the clinical picture of Simmond's disease. Partial removal or incomplete destruction of the anterior lobe permitted an indefinite survival period, but all animals were obese, dull, inactive, had no appetite and poor genital development. Removal of the posterior lobe with the anterior functioning produced the classical picture of diabetes insipidus.

Disorders of the pituitary gland in childhood may cause a number of well-defined clinical syndromes. However, since its functions are multiple and diverse, it is understandable that many pituitary problems do not fit exactly into any precise classification.

Defining abnormalities strictly on the basis of hyper- and hypopituitary disease is not sound, as the activities are often dissociated in the sense that excess or lack of function in one direction is not necessarily associated with disturbances of other functions. Deficiency or hyperactivity must be considered in groups according to the varied physiology of the gland. The classification of Goldzieher is based on this consideration, and is as follows:

1. Disturbances of growth
 - a. Gigantism, abortive hyperpituitarism, secondary hyperpituitarism of the eunuchoid
 - b. Pituitary dwarfism and infantilism
2. Disturbances of sex
 - a. Precocity
 - b. Secondary hypogonadism (Fröhlich's syndrome and Cushing's disease)
3. Disturbances of nutrition
 - a. Obesity
 - b. Simmond's disease
4. Disturbances of carbohydrate metabolism
 - a. Hyperglycemia (pituitary diabetes?)
 - b. Hypoglycemia
5. Disturbances of salt and water metabolism
 - a. Diabetes insipidus
 - b. Pituitary retention syndrome

It must be emphasized again that in actual practice few cases fit into this or any other classification, due to the dissociation of pituitary function.

Disturbances of Growth

Excess activity of the growth hormone can result in (a) gigantism, (b) abortive hyperpituitarism, or (c) secondary hyperpituitarism of the eunuchoid. All are characterized by excessive height.

Gigantism, which is characterized by an excessive secretion of growth hormone before the

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epiphyses unite, is practically always due to an eosinophilic adenoma of the anterior lobe. Excessive growth becomes evident during childhood, but is accentuated in adolescence. The clinical picture varies, although most often eventual depression of sexual activity, hypothyroid manifestations, and some degree of mental retardation occur. Forty per cent of giants have acromegaly, which occurs only after closure of the epiphyses. *Treatment* depends on the character of the pituitary lesion. The presence of an intrasellar tumor with ophthalmologic findings calls for immediate radiation therapy. If, despite radiation, ophthalmologic findings persist or headaches become more severe, surgery is indicated. If no tumor can be demonstrated, and there are no eye findings to suggest a rapidly expanding lesion, conservative therapy with hormones is advisable in those patients whose growth is unquestionably excessive. The object is to suppress growth activity by increasing the concentration of sex hormone in the blood. In girls, progynon B or other estrogenic substance can be used but, due to the cost of such products, stilbestrol is the treatment of choice; this is given in the dosage of $\frac{1}{2}$ to 1 mg. daily until growth is arrested, then used intermittently. In boys, testosterone propionate by injection (25 mg. three times weekly), methyltestosterone orally (10 to 20 mg. daily), or testosterone pellets (50 to 100 mg.; good for six weeks) may be used at the onset, reducing dosage when growth is arrested. With any of the above medications, overstimulation of sex activity is a sign to reduce dosage.

Abortive hyperpituitarism is the term given to a less marked activity of the growth hormone where no tumor can be demonstrated. Many of these cases are thought to be caused by the so-called "subclinical adenoma," which is demonstrable only at autopsy. One investigator reported an incidence of 22 per cent of these small adenomas in a large series of patients who had come to autopsy. Accentuated growth often subsides spontaneously, but sex hormones should be employed if excessive growth continues through puberty.

Secondary hyperpituitarism of the eunuchoid is marked by exorbitant growth caused by a normal amount of hormone acting over an abnormally long period, as the epiphyses remain open due to decreased activity of the gonads. In this type of giant the genitals are always greatly underdeveloped. Sex hormones at the time of puberty are indicated.

Deficiency of the growth hormone results in either dwarfism or infantilism.

Dwarfism is caused by a malformation or destruction of the anterior lobe due to tumor, inflammation, atrophy, or tuberculosis. The commonest cause is a suprasellar tumor which interrupts the connection between the mid-brain and the pituitary gland, resulting in atrophy of the anterior lobe. The small stature usually becomes apparent before the fifth year of life. These children are well proportioned, have normal genital structure and average mental ability. The pituitary dwarf must be distinguished from the thyroid, chondrodystrophic, and rachitic dwarfs, who present other associated signs. *Treatment* is not satisfactory; growth hormones may be tried, but must be continued for years. Implantation of calf pituitary tissue may be helpful, but this is still in the experimental stage, and I was unable to obtain any information on its use in humans. Bronstein, at the University of Illinois in 1946, reported a spontaneous cure of a pituitary dwarf who received no medication whatsoever. His patient, a girl, was 11 inches and 37 pounds below the average at the age of 12 years; she menstruated at age 20, and became engaged to marry at the age of 22; her height was 59 inches and her weight 103 pounds at age 20½.

Infantilism is characterized by a more moderate retardation of growth, genital hypoplasia, and undernutrition. Genital hypoplasia calls for gonadotropic or sex hormone therapy. Until age 12, the best therapy is a combination of chorionic gonadotropin (500 units) and anterior pituitary extract (1 cc.) given two or three times weekly for four months. If this combination is not effective, or if the patient is first seen at the age of puberty, sex hormones should be employed. If there are associated signs of thyroid or adrenal deficiency, other appropriate endocrine products are also indicated.

Disturbances of Sex

Overactivity of the pituitary sex hormone is caused by a tumor or hypertrophy of the anterior lobe and results in sexual precocity. It is associated with exaggerated height, increased bone age, and normal body proportions. Roentgenograms of the skull showing abnormal expansion of the cancellous bone and frontal sinus, plus the presence of follicle-stimulating hormone in the urine, are valuable diagnostic aids. *Treatment* is conservative unless a pituitary tumor can be demonstrated. Excessive menstrual bleeding can often be controlled by stilbestrol or testosterone,

although the masculinizing effect of the latter must be watched. If cystic ovaries result from the prolonged overstimulation by pituitary sex hormone, surgical resection or radiation must be employed.

Deficiency of the pituitary gonadotropic hormone results in hypoplasia of the genital organs. This usually does not occur alone, but as part of a general pituitary disorder. This deficiency is apparent in girls only at the time of maturity, but earlier in boys in whom undescended testicles are an outstanding manifestation.

The classical gonadotropic deficiency syndrome is known as *Fröhlich's adiposogenital dystrophy*. Clinically, these children are characterized by short stature, obesity, typical girdle-type fat distribution, at times retarded bone age, mental retardation, or behavior disorders. Polydipsia, polyphagia, polyuria, and enuresis are common. If a suprasellar tumor is the etiologic factor, diabetes insipidus may be present. From the laboratory standpoint, the abnormal metabolic state is evidenced by: (a) low basal metabolic rate, (b) low fasting blood sugar, (c) flat or hypoglycemic tolerance curve, and (d) increased blood uric acid level. *Treatment* consists of the following measures: (a) dietary restriction—high protein, low fat, 1000 calorie diet, with salt and water both restricted; (b) stimulation of metabolism with thyroid extract ($\frac{1}{2}$ to 3 grains daily) even in the absence of obvious hypothyroid signs; (c) benzedrine and ephedrine in older children to depress the appetite and elevate blood pressure; (d) posterior pituitary extract (3 minims or more three times weekly) if necessary to curb excessive thirst; (e) development of genital organs—this is best accomplished by combining pituitary extract (1 to 2 cc.) with urinary gonadotropins (250 to 500 units) two or three times weekly for four months. If puberty is delayed, sex hormones should be employed.

Dorff in 1936 studied the effects of various hormonal substances in patients with Fröhlich's disease. He obtained excellent results with anterior pituitary extract, thyroid, and diet restriction combined; with anterior pituitary extract alone, the genital organs responded in a remarkable manner, but no improvement was noted in obesity, feminine body contour, or osseous development. Jacobson and Cramer in 1937 reported on various pituitary deficiencies and concluded that a combination of anterior pituitary and thyroid extracts was generally very effective.

Another type of hypogonadism due to a pituitary disorder is known as *Cushing's syndrome*. This picture is also seen with tumors of the adrenal gland, but if on a pituitary basis it is always due to a basophilic adenoma of the anterior lobe. The general appearance and fat distribution are similar to Fröhlich's syndrome, but Cushing's disease is marked by several significant distinctions: (a) exaggerated height; (b) minor hypoplasia of the genital organs; (c) abnormal expansion of the diploe, and hyperpneumatization of the frontal sinus, as evidenced by roentgenograms of the skull; (d) polydipsia and polyuria; (e) positive ophthalmologic findings, and (f) the presence of prominent purple striae on the body. *Treatment* consists of radiation of the basophilic adenoma.

Disturbances of Nutrition

Occasionally, cases of pure pituitary obesity without associated endocrine disturbances are seen; almost without exception these are limited to adult life.

The syndrome known as *Simmond's disease* represents a total loss of pituitary function. When seen in children, it is usually superimposed upon a partial deficiency, as in dwarfism or infantilism. The outstanding manifestations are characterized not only by pituitary insufficiency but also by secondary adrenal involvement which is always present. They include arrest of growth, loss of weight, atrophy of the genital organs, adynamia, hypoglycemia, dehydration, negative salt and water balance, and a peculiar craving for salt. *Treatment* is very unsatisfactory. Implantation of anterior lobe tissue may prove helpful. The secondary adrenal disorder must be corrected.

Disturbances of Carbohydrate Metabolism

Hyperpituitary states are usually associated with hyperglycemia.

Hypoglycemia is often seen in children who show pituitary deficiencies pertaining to growth or genital development. However, it also occurs alone and is manifested by: (a) increased appetite and craving for sweets, (b) obesity, and (c) abnormal nervous and mental reactions. Behavior disorders and mental retardation are significant associated findings; cerebral tissue depends upon sugar for its fuel and cannot function normally if the blood level is too low. The diagnosis of pituitary hypoglycemia depends upon ruling out other sources of disturbed sugar metabolism,

such as hepatic, adrenal, or pancreatic. *Treatment* consists of: (a) dietary management—the diet must be low in carbohydrate (to discourage the production of insulin), high in protein and fat, and food should be distributed over at least five meals per day; (b) anterior pituitary extract (1 cc. three times weekly) or oral desiccated anterior lobe substance (5 grains, three times daily); (c) thyroid extract if obesity is present.

Disturbances of Salt and Water Metabolism

Destruction of the posterior lobe, provided the anterior lobe is still functioning, results in *diabetes insipidus*. This destruction may be due to tuberculosis, syphilis, tumor, or encephalitis involving the hypothalamus. Diabetes insipidus is marked by polyuria, excessive thirst, and loss of weight, which symptoms may or may not be associated with other pituitary abnormalities. *Treatment* must be directed at the underlying cause if one is found. Posterior pituitary extract is employed in any one of the following available forms: (a) 1 cc. injections twice daily, (b) pitressin in oil ($\frac{1}{4}$ to 1 cc. daily), (c) intranasal

application on tampons for thirty minutes twice daily.

The pituitary retention syndrome is caused by a small adenoma of the anterior lobe which does not cause neighborhood symptoms, but which does press on the posterior lobe. It is characterized by: (a) so-called salt and water type of obesity; (b) symptoms referable to the prevalent site of salt retention, i.e., urticaria (skin); rhinitis, sinusitis, or asthma (mucous membranes; headache or convulsions (brain tissue); (c) presence of other pituitary disturbances in some cases. *Treatment* is accomplished by the following measures: (a) salt completely restricted, and fluids limited to 1500 cc. daily; (b) ammonium chloride ($7\frac{1}{2}$ grains three times daily) to release retained sodium chloride; (c) atropine and phenobarbital in adequate dosage to control convulsions in cerebral cases; (d) posterior pituitary extract to decrease thirst and hasten elimination of chlorides; (e) thyroid extract because of its diuretic effect; (f) anterior pituitary extract if other pituitary disorders are apparent.

"BY APPOINTMENT ONLY"

Keeping office hours is an important part of the practice of medicine. They can be pleasant when well organized and hectic when everything is in a state of confusion. It is needless to say that better work is accomplished when everything is running smoothly. This is important in this day and age when the medical profession is being scrutinized as never before.

Opinions vary as to the relative merits of taking each patient in turn or by appointment only. Many physicians selected the appointment system on the theory that it adds prestige without realizing that they might do better if they used the other method. It means working on a rigid schedule and those who do not have the ability or inclination to do this will do better work if they abandon the idea. In other words, the type of office hours depends to a great extent upon the personality of the physician and not his type of practice.

There are many advantages to the appointment system. The patients are spaced to avoid waiting and the physician knows in advance how much work lies ahead. It also helps during vacation periods and when time off is needed for conventions. It is indispensable for those who allow an hour for each consultation and for those with a small practice who have outside work to do.

But these advantages are offset easily by several uncontrollable factors. A short visit puts the physician ahead but after a long consultation he is behind. The

schedule also is upset by emergencies and by those who "sneak" in to ask one question but stay long enough to discuss a dozen. Sooner or later the appointments lag behind; the physician is upset and so are the patients. To wait an hour to see a physician is not unusual, but to wait an hour after making an appointment is another matter. It ends so often with no one taking appointments seriously.

In our opinion, the appointment system should be selected if the physician can work on schedule; otherwise, he should just hold hours. A decision is in order because it leads to the practice of better medicine.—*Illinois Medical Journal*.

NINE CASES OF DIPHTHERIA—TWO DEATHS

Extra! Extra! Read all about it—in the PENNSYLVANIA MEDICAL JOURNAL, page 468, this issue.

Did it happen in 1909 in some remote district in the deep south, or the far north?

No! It happened in Pennsylvania in 1949, and the same thing may happen in almost any town or township.

Why? Read all about it (page 468) and then do something about it—at least for the preschool children in your own practice and in the schools of your own district.

The Roentgenologic Aspects of Anthracosilicosis

WILLIAM J. CORCORAN, M.D.
Scranton, Pa.

THE TERM "anthracosilicosis" is a descriptive title for the form of pneumoconiosis commonly called miner's asthma. It is a chronic disease due to breathing air containing dust generated in the various processes involved in the mining and preparation of anthracite coal. It is characterized anatomically by generalized fibrotic changes throughout both lungs with the presence of excessive amounts of carbonaceous and siliceous material, usually by compensating emphysema, and often by cardiac changes in the later stages of the disease.

For descriptive purposes we divide anthracosilicosis into three stages. The first stage consists of a bilateral peribronchial perivascular fibrosis; the appearance is uniform and symmetrical. A diagnosis cannot be made in the first stage. The second stage consists of nodule formation and it is the most characteristic appearance of the disease; usually the nodules are no more than 6 mm. in diameter. In unmodified silicosis the nodules usually average 12 mm. in diameter. Seldom do we see calcification in a nodule caused by anthracosilicosis; however, we do see it in silicosis very often.

In the second stage the nodules are uniformly distributed throughout each lung and it is amazing to see how symmetrical the condition becomes. When the conglomeration appears, the symmetry is broken and the appearance in each lung is different and quite irregular. Most of the conglomerate areas are in the part of each lung opposite the hilum, and it is rare to see large conglomerate areas in either base. When cavities appear they are usually tuberculous, although we have seen abscesses occur that contained large cavities and they were not caused by tuberculosis.

When the nodules begin to coalesce and there are conglomerate areas in the lungs, we arrive at the third stage. We are not prepared to state what causes the conglomeration. It is not the coalescence of nodules alone, because we see cases in which it exists and nodules cannot be

seen on the roentgenogram. It must be stated that a soft nodule of less than 3 mm. in diameter in the lung cannot be seen on the roentgenogram.

It is our belief that infection plays a part in conglomeration and is the major cause of disability. It has been our experience over twenty-five years that when a person has been exposed to a silica hazard it took from five to seven years before any distinctive changes could be seen on the roentgenogram. It is universally accepted that the only way in which the diagnosis can be made is by roentgen examination.

A fluoroscopic examination is essential, as this shows the movement of the diaphragm and that information cannot be obtained otherwise. Roentgenograms made in inspiration and expiration are also essential. Use of the Potter-Bucky diaphragm is of value. Roentgenograms made in oblique and lateral projections are of secondary value, unless some other condition exists such as fluid, tumors, aneurysm, etc. While the changes are going on in the lungs, there are changes coincidentally in the mechanics of the chest. The accompanying emphysema produces a darker appearance to the lungs, the interspaces are wider, the costophrenic angles are deeper, and on account of the fact that the chest is approaching a state of fixed inspiration the heart shadow is smaller than average in the majority of cases. It is rare to see an enlarged heart in a case of anthracosilicosis.

We have never found any racial resistance to the disease. We believe that carcinoma of the lung is no more common in anthracosilicotics than in people who are not afflicted with the disease. We have not found tuberculosis more common in anthracosilicotics before the age of fifty, but we have found it more prevalent in them after fifty years of age. Active tuberculosis with anthracosilicosis is a rapidly fatal disease. Very few, if any, in our experience recovered sufficiently to resume work or even to survive for any long period of time. Both conditions together almost defy treatment.

Read at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 26, 1949.

Choice and Use of Chemotherapeutic Agents in General Practice

EDITOR'S NOTE: Under the above title, we are permitted to publish several summaries from a paper read by John A. Kolmer, M.D., at the 1950 Postgraduate Institute of the Philadelphia County Medical Society. Dr. Kolmer comments:

"While a large number of sulfonamide and sulfone compounds are available, yet clinical experience has more or less clearly defined their choice in the treatment of various bacterial infections. Furthermore, until the discovery of aureomycin, chloramphenicol (chloromycetin), and bacitracin, antibiotic therapy of infectious diseases was merely a choice between the administration of penicillin, streptomycin, or both. Nowadays, however, accurate clinical and/or laboratory examinations, along with clinical experience, are more important than ever in the choice of the antibiotic or combination of two or more chemotherapeutic compounds to be employed in the treatment of bacterial, spirochetal, rickettsial, and viral diseases."

1. Choice of Sulfonamide Compounds

Ordinarily sulfadiazine or sulfamerazine for oral and their sodium salts for intravenous administration are the compounds of choice.

For preoperative and postoperative administration in intestinal surgery, succinylsulfathiazole is probably to be preferred.

Gantrisin is recommended when there are evidences of renal dysfunction.

Mixtures of two or three microcrystalline sulfonamide compounds may be employed when (a) rapid absorption with high blood levels is desired, (b) when necessary for reducing the chances of renal obstruction due to crystalluria, and (c) for minimizing the occurrence of allergic reactions.

2. Choice of Antibiotic Compounds

In bacterial infections: penicillin, streptomycin (dihydrostreptomycin preferred because of lower toxicity), aureomycin, chloramphenicol (chloromycetin), bacitracin, and tyrothricin.

In rickettsial and viral infections: aureomycin and chloromycetin.

In mycologic infections: penicillin in actinomycosis.

In parasitologic infections: aureomycin and bacitracin in amebiasis.

Aureomycin, therefore, has the widest range in therapeutic activity.

Ncomycin has a wide range in antibacterial activity and is effective against streptomycin-resistant tubercle bacilli, but its clinical value cannot be stated at the present time.

Terramycin has a wide range in antibacterial activity, but its clinical applications and value have not been fully determined.

3. Principles in the Choice of Chemotherapeutic Compounds

With all of these compounds now available, accurate clinical and or bacteriologic diagnosis is more important than ever.

In bacterial infections sensitivity tests should also be employed as frequently as possible for the detection of natural or acquired resistance.

In rickettsial and viral infections the choice depends entirely upon clinical diagnosis and experience.

Therapeutic effectiveness is the criterion of most importance and especially in the treatment of serious infections.

The relative toxicity of compounds, their cost and the ease of administration, along with the total expense of treatment, also require careful consideration.

4. Principles in the Use of Chemotherapeutic Compounds

Avoid their indiscriminate and unnecessary use as much as possible.

In severe infections institute treatment as promptly as possible on the basis of clinical diagnosis. Change treatment if/or when necessary according to the results of bacteriologic examinations.

In acute infections give large initial or priming doses. In these cases large doses over a short period of time are preferred to small doses over a long period.

Do not stop treatment too soon; continue until the patient is afebrile for at least three to five or more days.

Do not forget that adequate surgical or other adjuvant measures may be required.

This series of summaries will be continued in the June PENNSYLVANIA MEDICAL JOURNAL under the titles: 5. Natural and Acquired Resistance in Chemotherapy; 6. Causes of Treatment Failures in Chemotherapy; 7. Bacterial Sensitivity Tests in Chemotherapy.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

A SMALL COMMUNITY'S OWN HOSPITAL

Today in every community there is a need for hospital facilities. Communities of 5000 population or less need small hospital units. This is becoming increasingly necessary because of the educational and training requirements demanded of younger physicians. Being hospital trained, they are very reluctant to practice at any great distance from these services. Progressive communities that need physicians must provide hospital facilities if they are to attract younger men.

Small communities have little to offer a well-trained and competent younger physician unless hospital services are provided within a minimum driving distance. Ten to fifteen mile trips, two or three times daily, to the nearest hospital become very tiring and discouraging.

Interest in a community hospital project must be stimulated by the local medical profession. They should urge interested people to form a hospital association and secure policy and management setups under the by-laws of the American College of Surgeons.

Three questions usually provoke considerable discussion: (1) "How much money can we raise in the community for the building of a

hospital?" (2) "How big shall the hospital be?" (3) "How can we maintain the hospital after we have it built?"

Contrary to public opinion (and some medical opinion), a small community hospital can be erected without government help and maintained on a paying basis and continue to provide good medical care to the community.

The Union City Hospital was designed by a small town architect. *It was built with funds raised by public subscription without government or state aid in 1949 at a cost of \$90,000. There is a balance of \$16,000 to be paid in the next two years. It was built on a cost-plus basis with local labor on the major portion of the work.* The radiant heating, floor covering, and roof were on contracts. It has a potential capacity of 34 beds.

The hospital is of a story and a half construction. The main floor contains the waiting room, office, x-ray and emergency rooms, operating and delivery rooms, nursery and isolation rooms. All patients' rooms have a pleasant southern exposure, a large picture window, and all modern conveniences including oxygen outlets and telephone jacks. The building is soundproofed and contains a large meeting room in the basement

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

where the auxiliary, board, staff, and nurses meet. It also serves for clinical facilities and could accommodate twenty cots in an emergency. The basement also contains the kitchen, nurses' dining room, laundry, storage space, and furnace room.

This hospital has been in full and continuous operation for one year. It is supervised by an experienced nurse with a staff of four registered nurses plus eight nurses' aides, a bookkeeper, cook, laundress, and janitor. The medical staff consists of the writer as chief and four other local physicians with consulting staff from nearby Erie, Pa. hospitals.

The operating cost is approximately \$4,800 per month. The average monthly census has been 96 patients. There were 246 babies born in the hospital, and 158 major operations and 394 minor operations were performed during the year.

This small community has proved that hospitals can be built without government aid at a cost of approximately \$3,000 per bed and maintained at no additional cost to the community. This is largely possible through prepaid hospital insurance programs and the cooperation of the local physicians.

The Union City Hospital will be host to the Eighth Councilor District meeting on Wednesday, June 21, 1950. Dr. Philip Thorek, of Chicago, guest speaker, will discuss "The Acute Abdomen." All physicians are invited to attend the meeting and to inspect the hospital on that date.

GEORGE H. LEDGER, M.D.,
Union City, Pa.

THE 1950 SCIENTIFIC PROGRAM

The scientific program for the 100th annual meeting of The Medical Society of the State of Pennsylvania will open on Oct. 16, 1950, in Convention Hall in the City of Philadelphia.

The members of the Scientific Work Committee have endeavored to follow the plan inaugurated by the committee of 1949 when the House of Delegates, under the advice of President Engel, requested that the work of the committee be handled by the original component sections, namely, Medicine and Surgery. Instead of abolishing the specialty sections as was contemplated, they were retained with their chosen representatives as an Advisory Committee to the

Committee on Scientific Work. This group has been helpful in suggesting specialty topics related to medicine and surgery and in securing speakers on specialty subjects.*

To the Scientific Work Committee has been added a Subcommittee on Television under the able chairmanship of Dr. Kendall A. Elsom. Instruction will be televised in color to Convention Hall each morning emanating from various Philadelphia hospitals. The pharmaceutical firm of Smith, Kline & French Laboratories is making this very effective and direct visual instruction possible.

An innovation this year will be the introduction of study clubs. This part of the program will be presented on the afternoon of October 19 from 1 to 5 p.m., and will be planned by specialty groups. This form of instruction lends itself as well to a small group of five to ten as to a larger group of fifty, more or less. The mode of instruction is informal and each study club is composed of a moderator, instructors, and the doctors in attendance as students, who should be both full- and part-time specialists as well as general practitioners. The chairman of the subcommittee is Dr. Paul C. Craig, of Reading, who long has advocated this method of graduate study.

The scientific program will open on Monday, October 16, at 10 a.m., with a meeting combining the Sections on Medicine and Surgery. There will be a total of six such combined meetings during which the following subjects will be considered: (1) Hepatic Cirrhosis. (2) Antibiotics and Chemotherapeutic Agents. (3) Peripheral Vascular Diseases. (4) Pulmonary Tuberculosis. (5) The Management of Malignancy. (6) Ulcerative Lesions of the Bowel. Nine guest speakers will appear on this portion of the program.

Six morning or afternoon periods will be given over to each of the Sections on Medicine and on Surgery for the presentation of pertinent material. A number of guest speakers will be presented by these sections. Two clinicopathologic conferences will be held—one each for Medicine and Surgery. The material will be presented by a well-known pathologist and will be discussed by two equally well-known surgeons or clinicians.

* Pediatrics, Dermatology, Nervous and Mental Diseases, Preventive Medicine and Public Health, Pathology and Radiology are affiliated with the *Section on Medicine*, while the *Section on Surgery* has as its affiliates, Pediatrics, Obstetrics and Gynecology, Urology, Anesthesia, Eye, Ear, Nose and Throat, and Pathology and Radiology.

An adequate period of time is allotted at intermission, both morning and afternoon, for a leisurely visit to the exhibits.

The success of the scientific program in 1949 convinced everyone of the value of the changed type of program. The meetings never were better attended and interest ran high throughout the four days. True, the finely defined specialty groups lost some identity, but this loss may be readily compensated when one remembers that 70 per cent of our society membership is in general practice. With a program such as has been prepared, we believe that you will agree that we can thus best serve the greatest number of physicians in our society.

Succeeding issues of the JOURNAL will contain detailed information on the program of the Sections on Medicine and on Surgery with integrated material from the various specialties.

Plan to be present from Monday morning through the Thursday afternoon study clubs. The evenings will be taken up with entertainment and social affairs.

RALPH L. SHANNO, M.D., *Chairman,*
1950 Committee on Scientific Work.

THE MEDICAL BUREAU MOVEMENT

The success of medical-dental economic units throughout the country proves that there is a definite need for a reliable unit that offers some solution and assistance on the business side of the professions. A specialized business office that functions as an authorized agent for members of the medical and dental professions in the general field of medical-dental economics was realized in 1937 by members of the Allegheny County Medical Society and resulted in the establishment of the Medical Bureau of Pittsburgh. Since that time four bureaus have been organized in the Commonwealth and at this writing two others are in the process of formation.

The interest in this movement has been stimulated, on a county level, not through the original purpose of these units but rather because they have expanded their facilities and policies to encompass the field of public relations in health matters. Thus today the medical bureau movement is recognized as a vital influence in protecting the health welfare of the community by offering public health services to the mutual ad-

vantage of the professions and the community at large.

This trend has been evidenced within the past three years in line with the consciousness of the profession in its program of public relations. The charters of the medical bureaus, which are incorporated as non-profit organizations in the counties where they are established, place the public health services before the economic services as the primary purpose of incorporation. The charter reads "to maintain, operate and conduct a health information center, a 24-hour telephone exchange service, a 'budget for health' plan, a professional credit rating system, a bonded collection service, a confidential credit bulletin, published monthly for the guidance and protection of members, to do and to perform all services related to and connected with the medical and dental professions and accredited hospitals, which are nonprofessional in their nature and in fact." Thus the medical bureaus have aided and abetted the members of the professions, individually and collectively, in meeting the demands of the communities in matters of health and health services.

Space does not permit a detailed explanation of the many economic and public health services, so that only a few statements of policy and operation of the major services is herewith given.

Public Health Directory: Information regarding the members of the medical and dental societies is compiled in the bureau offices. Such information as name, age, race, creed, color, field of medicine, residence, office, hospital affiliation, membership in social and scientific societies, and other data in which a potential patient might be interested when selecting a physician. Information regarding voluntary health agencies, public health officials, hospitals, clinics, etc., is recorded for the information and assistance of interested persons.

24-Hour Telephone Exchange Service: Two distinct methods of operation are in effect. One is the Automatic Stop Board, whereby the member's private office and residence lines are connected with the board. All calls are automatically diverted into the board when the doctor, his office help, or members of his family are not available for phone coverage. The operators at the bureau intercept calls during that period and handle the calls according to instructions from the doctor. The other method is the Alternate Listing Service which consists of an insert in the telephone directory to the effect that if the doctor

cannot be reached at his private phone the caller is referred to the medical bureau for information and assistance. In conjunction with the Telephone Exchange, the medical society has organized an *Emergency Roster* of its members who will take emergency calls at all times.

The "Budget for Health" Plan: This is one of the most effective public health services in assisting patients to obtain needed medical, dental, and hospital care. It supplements the Blue Cross and Blue Shield plans for those individuals who cannot subscribe to these plans or whose contract does not cover the incurred obligations. It is a post-service plan whereby the member of the bureau is paid in full for services rendered, permitting the applicant to repay the bureau over a period of time *without added cost* to the applicant. An amendment to the Consumers Discount Company Act in 1947 permits exclusive operation of this plan by the bureau for its members and their patients. Since 1947 the Medical Bureau of Harrisburg has paid its members over \$80,000 through this plan with a total loss, to date, of \$136.

Bonded Collection Service: The primary economic service of the bureau is the collection of delinquent professional bills referred to the collection department. This is operated on a service fee basis approximately 20 per cent under the schedule of fees charged by commercial agencies. The service is operated in a dignified manner with the purpose of retaining the good relationship between the doctor and patient. The bureau in Harrisburg, since 1943, has received for collection approximately \$692,000 in delinquent accounts and to date has recovered approximately \$410,500. This result is realized through a knowledge of good business principles and professional ethics, and the desire of the bureau to assist patients in meeting professional obligations rather than to press through collection tactics.

Professional Credit Rating: The purpose of this service, through the centralization of credit information on professional paying habits of individuals, is to protect the members from the unscrupulous individual who has little or no regard for payment of his medical bills. The bureau attempts to educate the patient-debtor that doctors are not to be "paid last, if at all"; that the professional bill must be paid in proportion to the ability to pay commercial obligations. A reciprocal arrangement is in effect with the commercial credit agency whereby nonpayment of profes-

sional accounts reflects unfavorably on the commercial credit standing of an individual.

The medical bureau may also serve as the headquarters of the county medical society. The Medical Bureau of Harrisburg attends to all business details of the Dauphin County Medical Society and its manager is the executive secretary. In this way the personnel, facilities, and time of the bureau are utilized to serve the society at a cost far below that required to establish an individual office.

Membership in the bureau is limited to members in good standing in the county medical and dental societies. Financial support is derived through annual dues and service fees. The bureau is nonprofit and officers serve without compensation. Control and management are vested in a board of directors by and from the membership.

The bureaus, wherever established, have won the respect of the members of the profession by their efficient operation and regard for the ethics of the profession. These bureaus have taken the detailed office work from the hands of their members, thereby giving them more time to devote to the practice of their profession. The opinion of the board of directors of existing bureaus is expressed in the following delivered recently at an organizational dinner meeting: "In our community we have felt the value of the bureau to its members as well as to the public. . . . We can strike at the core of the problem as it arises by keeping in close contact with our patients through the services of our bureau. We have retained and increased the respect of the community toward our members because of the services we now offer them. This factor alone should encourage your society, whose membership is large enough to support a bureau, to contemplate its establishment here in The state medical society, through its public relations activities, is accomplishing a commendable job, yet I feel that we can and are doing a more direct personalized public relations job at the local level. If the state society would utilize some of its public relations appropriations to organize bureaus in those counties where they can be established, a dual result would be accomplished: first, the doctors would have protection and assistance in their economic problems, and second, good public relations on a direct personal basis would be realized."

This brief analysis of the medical bureau movement is presented for the purpose of stimu-

lating interest in the establishment of a bureau in those areas able to support such a unit. The writer, through 13 years' experience in the field of medical-dental economics and public relations, is interested in the problem of the professions and is willing to lend assistance to any society contemplating the establishment of such an organization.

ALBERT S. COBB, Manager,
Medical Bureau of Harrisburg.

A RECORD BREAKER

The 38th Annual Conference of County Society Secretaries and Editors (none held in war years, 1942-45), held in Harrisburg March 2 and 3, was an outstanding success from several angles.

The attendance was 40 per cent greater than that of any previous conference. Thirty-eight county societies were represented by the secretary or editor, or both; 34 societies by the president or president-elect, and 31 societies by the chairmen of such committees as Public Health Legislation, Medical Economics, or Public Relations.

The program as printed on page 154 of the February PENNSYLVANIA MEDICAL JOURNAL was presented without disappointment as to schedule or quality. It included two "firsts" in the fine history of the 42-year-old annual conference; namely, clever dramatizations of the separate themes which the State Society's Public Relations Committee and the Medical Service Association of Pennsylvania frequently address to the medical profession and the people of Pennsylvania.

The 30-minute sketch written by Mrs. Roy Jansen, who coached the cast of players drafted from the office staff of the Public Relations Committee, was cleverly written and realistically enacted. Space will not permit mention of the individual roles enacted by the Misses Saltzman, Raub, Treadwell and Rider, and Messrs. Brown, Hutchison, Jansen, and Young, all of whom entertainingly brought to their appreciative audience in unique form the profession's pressing responsibility to inform all persons contacted regarding the contrasts between *compulsory* and *voluntary* insured medical service and hospital care.

During the Friday morning program, the



President E. Roger Samuel, *left*, and President-elect Harold B. Gardner, *right*, confer with George F. Lull, Secretary and General Manager of the American Medical Association at the 1950 Conference of County Society Secretaries and Editors.

Medical Service Association of Pennsylvania employed representatives of the Harrisburg Community Theater to skillfully depict across the footlights for the conference audience the practicing physician's star role in arousing and sustaining, by the excellence of the professional service he renders, the support of subscribers to Blue Shield and other forms of insured medical service in Pennsylvania.

Philadelphia Medicine, for March 11, gave a generous and readable write-up of the conference from which we quote:

"The conference opened with a discussion of the Grievance Committee project by Lester H. Perry, executive secretary, and Dr. Louis W. Jones, first vice-president of the State Society. Mr. Perry described the Colorado State Medical Society's plan which has been in existence for several years. The purpose of this committee is to receive complaints about physicians, principally from the laity; to determine which ones are justified; and to investigate them thoroughly in order to effect a satisfactory adjustment between physician and layman or refer the matter to the board of censors and the society for more drastic disposition.

"Dr. Louis W. Jones, chairman of a Board of Trustees committee appointed to study the recent action of the AMA in recommending the establishment of such committees in every state medical society, believed it more feasible to organize them on a county level. In certain areas the board of censors might be reactivated to handle the problem, with the possibility of increasing the number of censors. Dr. Donaldson requested those present to take the subject back to their county societies for study and consider-

ation with the view of advising their 1950 delegates."

Enough Practicing Physicians?

"Dr. William S. McEllroy, dean of the University of Pittsburgh Medical School, analyzed the present situation with regard to the supply of physicians in relation to the potential demand and future trends and said that there are insufficient data to form any definite conclusions. He stated that there are two opposing views—one group believing that there are sufficient physicians and the other that there is an immediate need for additional medical schools. He discounted statistics reflecting the annual number of applicants for medical school training because of the fact that many of those desiring a medical education file their applications with one to four or more medical schools (see page 62, January PENNSYLVANIA MEDICAL JOURNAL). He believes the present shortage of interns to be a dangerous situation.

"With approximately 8000 internships to be filled and a total of approximately 5500 medical students graduating each year, he called attention to the fact that the AMA is studying the problem of the supply of physicians. The results of this study will be very important with respect to any further steps which should be taken in the matter."

"A considerable number of county societies, including Philadelphia, made reports on the organization and operation of such programs (see page 524, this issue; also the June issue).



Pictured above are six women physicians who attended the 1950 Conference of County Society Secretaries and Editors. They are, left to right: Drs. Pauline K. Wenner, Allentown, secretary, Lehigh County Medical Society; Frances D. Taylor, Philipsburg, president, Clearfield County Medical Society; Alice E. Sheppard, Pottstown, secretary, Montgomery County Medical Society; M. Louise C. Gloeckner, Conshohocken, second vice-president, Medical Society of the State of Pennsylvania; Persis Straight Robbins, Bradford, secretary, McKean County Medical Society; Mary Baker Davis, New Castle, president, Lawrence County Medical Society.

Dr. Donaldson emphasized the importance of these programs in terms of a public need as well as good public relations. He encouraged other county societies to consider seriously the organization of similar plans."

Home Care of Patients

"Mrs. Benedict H. Birkel, president-elect of the Woman's Auxiliary to the Lebanon County Medical Society, described an excellent program of the Auxiliary to provide hospital bed facilities at home for elderly patients suffering from chronic illness or needing convalescent care but capable of being treated in their homes. This program has achieved amazing results on a limited expenditure of money. Dr. Richard R. Hoffman, of Lebanon County, emphasized the importance and success of home care of patients who do not definitely require hospital care. He called attention to the fact that 35 per cent of elderly and convalescent patients can be adequately cared for at home and stressed the following advantages: (1) lower cost; (2) good medicine can be provided; (3) strengthens physician-patient relationship; (4) psychologic effect on patient from being able to remain in his home atmosphere."

"One of the outstanding presentations of the conference was a report by Dr. George S. Klump, chairman of the Board of Trustees of the State Society, concerning the recent public health survey (Keystones of Public Health for Pennsylvania) which was made in 1948 (Dr. Klump's report appears on page 411 of the April PENNSYLVANIA MEDICAL JOURNAL)."

Dr. Lull Dinner Speaker

"During the dinner program on Thursday evening, Dr. George F. Lull, secretary and general manager of the AMA, outlined some of the present important activities of the AMA in the fields of health legislation and medical economics. He reported that the payment of 1950 AMA dues was very encouraging. He stressed the importance of bringing our influence to bear on those groups who have not yet made up their minds concerning the controversy between compulsory and the voluntary forms of health insurance rather than wasting a good deal of our efforts on many groups who share our philosophy. He reported that conferences were being held by the AMA and national representatives of commercial insurance companies to work out a program to provide health insurance on a vol-

untary basis for as many persons as possible."

Dr. Lull not only spoke for thirty minutes and answered many questions for an additional period of twenty minutes at the dinner meeting but he was in attendance at all sessions of the conference as well as at the meetings of our Board of Trustees on Thursday and Friday. The Board extended him a vote of thanks for gracing our conference with his presence and of sincere appreciation for his time and for the inspiration he brought to our society.

The following members were chosen to serve as the program committee for the 1951 conference: Secretary Wilbur E. Flannery, Lawrence County, chairman; Editor Carl B. Lechner, Erie County; Secretary Joseph W. Raymond, Cambria County. Trustee and Councilor James Z. Appel, Lancaster County, continues as adviser to the committee.

The record of attendance from each county may be found in the Officer's Department, page 525, this issue.

A SALUTE TO JEFFERSON ON ITS 125TH ANNIVERSARY

Having observed our centennial not long ago, we respect the pride with which the Jefferson Medical College of Philadelphia celebrates this spring the 125th anniversary of its founding.

This seventh oldest, and until recently the largest, of the nation's medical schools was a century and a quarter old on March 8. Jefferson will honor the memory of its founder, Dr. George McClellan, at a memorial luncheon on May 25 in Philadelphia of the Newcomen Society of America and other special occasions in the commencement period.

When Jefferson was formally opened in 1825, Philadelphia was the largest American city with 138,000 inhabitants. It was already regarded as the "Cradle of American Medicine," being the seat of the Colonies' earliest medical school of the University of Pennsylvania.

Jefferson was launched in the midst of much opposition to the founding of a second medical college in Philadelphia and its early career was threatened several times. A small group of physicians, led by McClellan, ambitious to teach medicine, made unsuccessful attempts to secure a charter from the Legislature. Counter-influence proved so strong that McClellan determined

upon finesse to secure for the college the right to grant medical degrees. In 1824 he proposed to Jefferson College, an institution founded in 1802 in Canonsburg in western Pennsylvania, that it establish a medical department in Philadelphia. The older literary college assented and Jefferson Medical College began courses in 1825. But the right to award the M.D. degree was still questioned until the Legislature enacted the necessary confirming statute just prior to the first commencement of the new medical school. Several years later, Jefferson was granted an independent charter with broad university powers.

In the founding year, McClellan started the infirmary which became immediately an adjunct for clinical instruction. This was the first clinic established in any college in the country. Thereby the Jefferson Hospital was launched that grew to become eventually one of the largest non-government hospitals in the country and the largest in Pennsylvania.

During the years that followed, under eminent faculties, Jefferson steadily gained in strength and prestige, until its fame became universal. In some of the earliest classes graduated were Samuel D. Gross, the great surgical authority, Washington L. Atlee, the abdominal surgeon, and J. Marion Sims, a founder of the science of gynecology.

Besides George McClellan, the early faculty included John Eberle, B. Rush Rhees, Jacob Green, Nathan R. Smith, Francis S. Beattie, W. P. C. Barton, Samuel McClellan, Daniel Drake, and John Revere, widely known men in their day. These were followed by such other prominent faculty men as Robley Dunglison, Joseph Pancoast, John Kearsley Mitchell, Charles D. Meigs, Thomas D. Mutter, Franklin Bache, Samuel D. Gross, Samuel Dickson, Robert E. Rogers, the younger Gross, J. M. DaCosta, Theophilus Parvin, Francis X. Dercum, Robert Bartholow, J. H. Brinton, William W. Keen, Hobart Amory Hare, John Chalmers DaCosta, and Thomas McCrae.

The success of the college has been largely influenced by those advances in practical teaching which have always given character to the school, chief among them being the early development of the system of college clinics. It has always been the aim of the school to develop excellent, all-round, practical clinicians.

During the century and a quarter of the institution's history, nearly 19,000 doctors of medicine have graduated to serve in all areas of the

world. More than 6000 of these graduates are living—the largest alumni group of any of this country's medical colleges.

In Pennsylvania, there are 2709 physicians who are Jefferson graduates, of whom 840 are in Philadelphia. Alumni of the school have been active in affairs of the Philadelphia County Society, the State Society, and the American Medical Association. Dr. George F. Lull, secretary and general manager, and Dr. Francis F. Borzell, speaker of the House of Delegates of the AMA, are both Jefferson alumni. Dr. Borzell, in addition to many other posts of leadership, was president in 1941 of The Medical Society of the State of Pennsylvania, a position held earlier by Jefferson's dean, Dr. Ross V. Patterson. Of the 89 presidents of the Philadelphia County Medical Society, 23 have been Jefferson graduates, three of the more recent having been Dr. Louis H. Clerf, Dr. Lewis C. Scheffey, and Dr. Theodore R. Fetter. This society's annual Strittmatter award was established by Jefferson's Dr. Isadore P. Strittmatter, president in 1928. The surgeons general of the Army in two world wars have been Jefferson graduates—General Merritt W. Ireland and General James C. Magee.

The Jefferson Medical College and Medical Center, with its complex of hospitals, clinics, and auxiliary institutions, is today one of America's important centers for medical education, patient care, and research.

The JOURNAL is happy to salute Jefferson on its 125th birthday and wish it further success in its service.

T. R. F.

NUTRITION AND ANEMIA

(EDITOR'S NOTE: This is the second of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania. With the present-day interest in applied physiology as displayed by clinicians, this series on its nutritional phase should prove timely, interesting, and instructive. Many readers of the appended editorial may find new light on the nutritional values of ascorbic acid, folic acid, and vitamin B₁₂.)

Within recent years the anemias have become more closely linked to nutritional deficiency. Frequently anemic patients manifest signs of nutritional deficiency of a multiple nature indicating that long-standing inadequacies in the diet have led to depletion of the body reserves of vitamins, proteins, and minerals. From the clinical standpoint, many patients have, in addition to poorly balanced diets, sources for chronic blood loss or illnesses, such as cardiovascular,

respiratory, or gastro-intestinal disease, which makes the obtaining of an adequate diet, or the appetite for it, a difficult problem.

Surveys of large segments of the population have shown that anemia in apparently healthy groups in continental United States is rarely correlated with specific dietary protein deficiency; elsewhere, as in India and Puerto Rico, hypoproteinemia and anemia are found frequently in combination, the anemia improving on protein repletion. In dogs, marked protein depletion or specific amino acid deficiencies have been demonstrated to cause anemia, which can be remedied by corrective feedings. About 96 per cent of the hemoglobin molecule is a sulfur-containing protein (globin); protoporphyrin and iron (heme) constitute the remainder. The protein nature of heme is demonstrated by the fact that N¹⁵-labeled glycine is the most effective nitrogenous precursor in the formation of protoporphyrin. The extent of the protein demands in hemoglobin synthesis can be appreciated when it is realized that the red cell life as determined by radioactive iron studies or by agglutination techniques is 120 days. This means that 0.85 per cent of the blood, or about 50 cc., needs to be replaced daily.

The production of hemoglobin appears to enjoy the top priority with respect to protein metabolism. In protein depletion studies, 1.5 to 4.0 times as much hemoglobin was formed as was plasma protein during the period of protein withdrawal. Antibody nitrogen, albumin, and globulin syntheses were reduced in the hypoproteinemic animals, while hemoglobin continued to be produced. Thus inadequate protein intake alone would not reduce hemoglobin production until other body proteins had been depleted.

A more important deficiency in the pathogenesis of anemia is that of iron. Using as a criterion the allowance recommended by the National Research Council, Youmans found that two thirds of 1200 persons were not receiving sufficient dietary iron. However, there was no correlation between the lack of iron and the incidence or severity of anemia found in this group. Iron deficiency anemia may be more often related to iron losses through bleeding, pregnancies, or other factors than to inadequate intake of iron. Despite this failure to ascribe hypochromic anemia to low dietary iron, this anemia will respond rapidly to the ingestion of iron and iron-containing foods such as meat, liver, leafy vegetables, and certain fruits. Low dietary iron has

been found in 32 to 70 per cent of patients with hypochromic anemia. Undoubtedly, multiple factors are operating in iron deficiency anemia including low dietary iron, decreased absorption (hypochlorhydria), increased requirements (pregnancy), and excessive losses (parturition, menstrual). Seldom is one factor alone responsible.

Another aspect of the relation of proteins to anemia is the investigation of the storage form of iron in plasma. Recently a beta globulin from Fraction IV-7 of the plasma fractionation experiments has been shown to bind and transport metal in the blood and to hold it available for the manufacture of heme. Studies of this protein in nutritional deficiency have not been made, but in the presence of iron deficiency there is an increase in the amount of iron-binding globulin in plasma while iron stores are low. In the anemia of infection, there is reduced metal-binding globulin and a marked reduction of serum iron.

Copper is also transported by this protein in the blood. Microcytic anemia due to copper deficiencies in the soil has been described in certain animals. In human adults there is no indication that copper is necessary for a hematopoietic response; however, in infants, copper has been shown to improve the reticulocyte response produced by iron therapy.

The role of water-soluble vitamins with respect to hematopoiesis is not clear in the human. Deficiencies in riboflavin will produce anemia regularly in animals; but, in the human, ariboflavinosis is not usually associated with anemia. Pyridoxine deficiency, which produces a microcytic anemia in animals, was recently induced in humans by the use of desoxypyridoxine, a metabolic antagonist of the vitamin. The clinical manifestations of pyridoxine deficiency were cheilosis, glossitis, and seborrheic skin lesions which disappeared on treatment with pyridoxine. The patients did not show anemia.

Pellagra may be associated with anemia of a normocytic or of a macrocytic type. The cause of anemia in aniacinosis is obscure, but may be related to the function of this vitamin in promoting cell respiration. A lack of the enzyme system dependent upon it may interfere with the survival of immature red cells.

Vitamin C has not been found to play a role in hematopoiesis. The anemia of scurvy is probably secondary to the hemorrhages of this disease; it responds to iron therapy as well as to ascorbic acid. Recent work emphasizes the im-

portance of ascorbic acid in reducing dietary iron to the ferrous state in the stomach for absorption. Some of the protein digestion products are equally effective in promoting iron absorption so that vitamin C and protein in the diet may definitely increase the availability of food iron.

Folic acid, a growth-promoting substance, has been considered to be a vitamin important in hematopoiesis, a deficiency of this factor producing a macrocytic-megaloblastic anemia and leukopenia in higher animals. The appearance of several reports on the effectiveness of folic acid in the treatment of macrocytic anemias of pregnancy following a lack of response to vitamin B₁₂ indicates that folic acid may be a necessary nutritional factor intimately associated with blood formation, and not just an active pharmacologic agent stimulating hematopoiesis.

Efforts to obtain an antipernicious anemia factor (APA) were culminated in 1948 by the discovery of vitamin B₁₂ extracted from fresh liver, and from cultures of *Streptomyces griseus*. It is probable that many maturation arrest anemias are the result of vitamin B₁₂ deficiency, although only minute amounts are necessary in its function as the erythrocyte maturing factor. Vitamin B₁₂ requires a substance in the gastric secretions for assimilation and therefore is probably the extrinsic factor as well as the APA factor. Deficiencies of vitamin B₁₂ may be produced by conditions which interfere with the assimilation of, the utilization of, or the storage of this vitamin. The glossitis and neurologic complications, as well as the anemia of primary pernicious anemia, respond to treatment with vitamin B₁₂.

The concept of anemia as primarily a nutritional problem is gradually gaining favor. It is clear that various deficiencies may be responsible in the pathogenesis of a variety of anemias excluding the hemolytic, hemorrhagic, and congenital. Certainly the successful management of these latter anemias requires close adherence to the established principles of dietotherapy.

CHARLES R. SHUMAN, M.D.,
Philadelphia, Pa.

ADEQUATE VITAL STATISTICS ALL-IMPORTANT

The cooperation between the Commission on Cancer of The Medical Society of the State of Pennsylvania and the Pennsylvania Department

of Health has been ideal for a number of years. Since the Division of Cancer Control was established in the State Health Department, there has been every reason to expect the chosen representatives of the State Medical Society to work hand in glove with the department, and no one has claimed disappointment in this respect. There are, however, grounds for complaint as to cooperation at the present time because many practitioners who are members of our state society are failing to report to the department the cases of cancer coming under their observation or care. The May, 1949 issue of the PENNSYLVANIA MEDICAL JOURNAL devoted a page to a communication from Secretary of Health Norris W. Vaux, M.D., wherein he earnestly requested all physicians to objectively recognize the fact that cancer (several years previously) "had been added to the list of reportable or notifiable diseases."

JOURNAL readers will find in this issue (page 521) a copy of the department's form "Report of Malignant Neoplasm." It is not a particularly complex form, and it is sincerely urged that for the sake of the light that needs to be shed upon the cause, cure, and/or end results of this dread killer every Pennsylvania physician will promptly upon arriving at a diagnosis of cancer report each case to the Division of Cancer Control, Pennsylvania Department of Health, Harrisburg, Pa.

The Commission on Cancer of The Medical Society of the State of Pennsylvania joins Secretary Vaux and the JOURNAL in urging the cooperation of every member of the Society in this effort to have all cases reported to the Department of Health. S. Gordon Castigliano, M.D., chairman of the State Society's Commission on Cancer, has recently stated that "unless we as physicians cooperate, the statistical program of the Division of Cancer Control will be of little value to the health of the citizens of this Commonwealth."

THE NITROGEN MUSTARDS IN MALIGNANCY

Suggestion for Reducing Toxicity

The nitrogen mustards, such as mechlorethamine hydrochloride (methyl bis (β -chloroethyl) amine hydrochloride, or HN₂), have proved their value as a chemotherapeutic modality in

certain forms of malignant disease, especially the lymphoblastomas. Unquestionably, these chemotherapeutic agents for intravenous administration strike the disease in its most remote hiding places. For a generalized malignancy, such as the lymphoblastomas, intravenous therapy with an effective anticarcinogenic agent is ideal.

As our experience with these drugs increases, we have come to question the advisability of three common clinical practices: (1) employment of nitrogen mustards only after other agents have failed; (2) their use only when the patient is in relapse; and (3) the method of administration generally employed. We should like to discuss these problems briefly in the order indicated.

Up to the present time the nitrogen mustards have unfortunately been used only as "rescue therapy" in cases recalcitrant to radiation. It is now urged that *newly diagnosed* cases be *started* on nitrogen mustard therapy. If this should prove ineffectual in a given case, no harm is done and little treatment time is lost; in fact, x-ray therapy in some instances may be made even more effective by such preliminary treatment. If, however, nitrogen mustard does induce a remission, the usefulness of radiation (which is still considered to be the best all-round method of treatment) may thus be saved for that period in the course of the disease when additional powerful therapeutic measures are needed.

For the past three years all patients with Hodgkin's disease who have been personally supervised by one of us (PLD) have been treated with mechlorethamine hydrochloride every six to eight weeks whenever possible, whether or not they were in remission. No radiation has been found necessary in these cases. Recently we have added this method of administration to the plan formerly in use, that of "treatment only when necessary."

We should like to discuss a method of administration that we have found to be superior to that which has been employed generally. When, by conventional therapeutic methods, diseases of the type often treated with the nitrogen mustards have had several years of periodic "token" radiation applied to localized areas, the large trunical marrow bed has been exposed to and may have been injured or depressed by the radiation. Under such circumstances, sites of previous bone marrow activity in the extremities may often become reactivated to compensate for the depression. This radiation effect was demon-

strated by the fact that, from among 25 patients examined, "needle biopsy" revealed signs of bone marrow activity in the tibias of 9 adults. The nitrogen mustards, even though they are introduced with care, may further depress marrow stores. It would seem to be desirable, therefore, to preserve any small islands of marrow activity in the long bones from the toxic effects of nitrogen mustard.

We attempted to accomplish this by excluding the general circulation from the limbs not involved either in the malignant process or in the intravenous procedure. When we did this, we believed the idea was original with us, only to find recently that the method had been suggested by Karnofsky* and the Memorial Hospital group. This is done by placing blood pressure cuffs upon all such extremities and inflating them above the systolic blood pressure. The cuffs are applied as near the trunk as possible. They are inflated just before the mechlorethamine hydrochloride is injected through the tubing of a rapidly running intravenous solution to which 50 mg. of heparin has been added. The cuffs on the uninvolved limbs need be kept inflated for only five to ten minutes (average six and one-half minutes), since it takes but a few minutes for the mechlorethamine to be cleared from the general circulation.

Although Karnofsky noted no objective evidence of lessened bone marrow depression, in our 11 cases thus treated over a period of twelve months no leukopenia or thrombosis has developed. Without this exclusion technique, at least 20 to 25 per cent of these cases would have been expected to show significant leukopenia by this time.

Although it is too early to appraise this "limb exclusion marrow preservation" method of nitrogen mustard administration, it appears to be based on theoretically sound principles and preliminary observations tend to demonstrate its efficacy in reducing toxic effects on the bone marrow. The same may be said of the plan of giving nitrogen mustard therapy a trial in early

cases before the institution of x-ray radiation, with administration of the drug every six to eight weeks, whether or not the patient is in remission at the time a given injection is due.

The purpose of this preliminary report is to encourage other investigators to try both the plan of early nitrogen mustard therapy that has been described and the "exclusion method" of preserving the function of such blood-forming foci as may be available in the long bones. In addition, the exclusion technique may possibly permit the administration of larger total doses of nitrogen mustard per course of therapy than has heretofore been possible, destruction of hematopoietic tissue being thus minimized.

PERK LEE DAVIS, M.D.,
CAPTAIN JULIAN LOVE,
LIEUTENANT ROBERT MOXON,
Staff of United States Naval
Hospital, Philadelphia.

The opinions or assertions contained herein are those of the authors and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

Methyl bis (β -chloroethyl) amine hydrochloride or HN₂ was supplied by Merck & Company, Rahway, N. J.

KEYSTONES OF PUBLIC HEALTH FOR PENNSYLVANIA

Adult Health

(EDITOR'S NOTE: This is the fifth of a series of guest editorials* planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.)

The background of events leading to publication of the report, "Keystones of Public Health for Pennsylvania," has been reviewed in a previous editorial.

The spectacular success in the control of many important communicable diseases, with marked reductions in mortality and the resulting shift in age distribution of the population, has turned the spotlight of public and professional interest to the health of adults.

Diseases prevalent in middle and older age groups are now the leading causes of death in

* KARNOFSKY, DAVID A., ABELMANN, WALTER H., CRAVER, LLOYD F., and BURCHENAL, JOSEPH H.: The Use of the Nitrogen Mustards in the Palliative Treatment of Carcinoma with particular reference to bronchogenic carcinoma, *Cancer*, 1: 634-656, 1948.

* This series of editorials is the subject of a communication from J. Moore Campbell, M.D., veteran Deputy Secretary of Health. See page 460, this issue, under the caption "Keystones Eight Inspire Debate."

Pennsylvania and throughout the country. There is every reason to believe that the development and application of preventive techniques in the special field of adult health should have a comparable degree of success.

At the present time, Pennsylvania's Department of Health, through its Division of Industrial Hygiene, carries on a program of adult health concerned chiefly with industrial workers. This program includes:

1. "The control of environmental factors of industrial health. This goes far beyond the negative phase of protection from harmful conditions and attempts to achieve the most healthful environment possible.
2. "Attention to medical services with regard to those causes of diminished efficiency, absenteeism, illness, or death due to industrial factors.
3. "Attention to the general health of the industrial workers, relating to such factors as nutrition, mental health, and those illnesses which attack any group of people of similar age group."

In spite of a lack of coordination with other divisions in the Department of Health and with local officials and medical groups, the Division has made commendable progress.

In planning for the future and to overcome the inadequacies of the past, the report recommends that a Geriatrics Unit be established and grouped with the programs under Health Conservation. This unit would be staffed with trained personnel, who would coordinate their work with other health and social agencies. Preventive techniques could then be successfully applied to control the great group of degenerative and allied diseases afflicting this important class of workers.

The report also recommends that the work of the Division of Industrial Hygiene be more actively integrated with that of the Department of Health. This division operates independently for all practical purposes and is described as a miniature health department in itself. This pattern represents policy based on three factors:

1. "The theory that industrial hygiene requires a specialized technique not common to the other public health programs.
2. "The policy of furnishing all services directly by vertical administration.
3. "The limited extent of activities of the Bureau of Health Conservation to explore and achieve the benefits of integration with other programs, and the application of other public health techniques to the industrial hygiene program."

This type of independent operation can be overcome and the benefits of sound public health administration made available to the great mass of industrial workers in Pennsylvania by putting into practice the simple and effective principles of cooperation and coordination in public health procedure.

In supporting an adequate program for Pennsylvania's future health and welfare, these important recommendations should be carefully studied by the members of the medical, nursing, and allied professions, who will have the task of carrying them to fulfillment.

JOHN D. YEAGLEY, M.D.,
York, Pa.

FREE ENTERPRISE HOSPITAL

An editorial in this issue of the JOURNAL holds much of specific interest for several communities in Pennsylvania, and of general interest for all who deplore the current extravagance in hospital construction and luxury in hospital accommodations for patients. The story of the Union City, Pa., hospital in detail may be obtained from George H. Ledger, M.D., who wrote the editorial. Their judicious approach and their first year's experience in meeting the hospital requirements of a town and township (population 5000) free from government aid and control is both revealing and encouraging.

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.—Section 3, Chapter I, Principles of Medical Ethics of the American Medical Association.

PSYCHIATRY AND RELIGION

It is my opinion that psychiatry and religion are separate from each other, that each has well-defined reasons for being. The psychiatrist is a physician who treats illness, illnesses which come about mainly perhaps by faulty early interpersonal relationships. Psychiatry is not a religion and in no sense of the word is it a substitute for religion.

In certain areas psychiatry and religion do have overlapping edges. Since this is so, and since both professions have the same goal in mind, cooperation rather than conflict is what is needed. And perhaps the two can come to contribute much more to each other. Perhaps it is time that the two professions compared professional notes in the attempt to make this a better world in which to live.—DONALD W. HASTINGS, *Northwest Medicine*.

INSTRUCTION IN RADIOLOGY

The duties of preceptors in radiology are, in my opinion, threefold: to imbue their charges with the scientific knowledge requisite to the practice of radiology; to ensure that their students possess the ability to express that knowledge verbally, in good oral and written form; to provide their residents with a detailed comprehension of the *business* of radiology. The first of these objectives is currently being attained in considerable measure, as indicated by the results of the examinations conducted by the American Board of Radiology. The fact that about a third of the applicants fail suggests the need of improvement in some instances.

The second desideratum is perhaps less generally recognized. Radiology and tissue pathology share the burden of being the two specialties in which the physician is judged by his colleagues, in large measure, on the basis of his written opinion. Surely, then, in these fields, a man must be able to express his thoughts lucidly, accurately, in good grammatical form, and with some semblance of "style." The teacher of radiology might well consider these matters, among others, in the selection of his residents. Beyond that, it is his duty to teach the vital importance of precise diction "by precept, and example, and every other method of instruction," as well as other matters more germane to the Hippocratic Oath.

The third responsibility of the teacher lies in a field in which there must be the greatest variation, both in the facilities available for study and in the interest of the instructor. The chief of radiology in a large private hospital will necessarily have a different attitude than the professor of radiology in a smaller medical school in which private medical practice may not be encountered. Neither of these men may be familiar with the techniques of efficient operation of a radiologic office. In any community in which men are being trained in radiology, there will be both private and public hospitals and radiologic offices in which economic problems of various types are encountered.

The young men who leave the sheltering walls of their hospital residencies will be called upon to make decisions in a competitive world for which they might

well be prepared in advance by those charged with their education. The practicing radiologist tends to be reticent about his income. Its sources, the details of agreements with hospitals, the mechanics of accounting and collection procedure in private practice, are discussed, if at all, in meaningless generalities. I believe that the best interest of our specialty will be served by greater candor with those who are to be our colleagues.—JAMES B. HAWORTH, M.D., Salem, Oregon.

PATRIOTISM ALL YEAR LONG

We think one of the greatest cures for what's wrong with things in the wonderful land of America is a rebirth of that wonderful old word comprising our headline. We can remember when the sight of the American flag sent a chill of pride through us. It still does. We can remember when the mere thought of famous old Americans and all the fine things they did and said brought a warm wave of gratitude for being able to live in the same country they did. The flag still waves for us.

We can remember when the initials U. S. or U. S. A. looked simply beautiful and meant the greatest country on earth. They still do.

We can remember, after being out of the country for a year, our greatest thrill was the sight of the Statue of Liberty in the New York harbor. We still think of that day and always will remember it as the most thrilling moment in our career. Every good American should experience this thrill.

Yet the newspapers, magazines, radio—and television, if your eyes are holding out—let us know that there are many young and old people floating around our land who hate it. They take from it, use its laws to their advantage, but hate it. They are so full of hate that they strain every adjective to its utmost to express their contempt, to sneer, to snicker, to plot and plan against us, to use the truth as if it had smallpox, hurling untruths in such quantities that their mere weight, they think, will convince people of their truth.

Well, so this is an old-fashioned 4th of July oration. It is a call to those of us who do not feel that America is a pool of evil to shout "enough" and out-shout the detractors. False statements are so thick these days that the mere mention that two and two make four sounds like a refreshing bit of wisdom. Let's do a little drum-beating for America and drown out the cynicism, the defiance of the ungrateful, and the morally soggy who want their cake without baking it.

If the fear of being blown to bits by atoms is what is undermining the fine old reliance of many Americans, we think the remedy is to forget the atoms and think of John Adams, forget the Franksteins and think of Ben Franklin, forget the liars and think of Lincoln—and if a propaganda is so darned wonderful when composed of 100 per cent untruths, why not a little shouting about the things that are true? Give us a drum and we'll beat the hide off it! The microphone of our new Time-Master just answered back, "Atta Boy!" (We have a special mouthpiece with inbuilt brain; it keeps up our morale a lot.)—*York Trade Composer*.

Attention!

YOUR HOTEL RESERVATIONS Should Be Made NOW!

FOR THE

One Hundredth Annual Session

PHILADELPHIA, OCTOBER 15, 16, 17, 18, 19

<i>Name and Location</i>	<i>Single</i>	<i>Double</i>	<i>Twin</i>
BELLEVUE-STRATFORD, Broad and Walnut Streets (Headquarters Hotel)	\$4.00 up	\$7.00 up	\$9.00 up
PENN SHERATON, Chestnut at 39th Street	4.00 up	6.50 up	7.00 up
BENJAMIN FRANKLIN, Chestnut at 9th Street	5.00 up	7.50 up	9.00 up
WARWICK, 17th and Locust Streets	5.00 up	.....	8.00 up
JOHN BARTRAM, Broad and Locust Streets	4.50 up	7.00 up	8.00 up
RITZ-CARLTON, Broad and Walnut Streets	5.50 up	8.00 up	8.00 up
SYLVANIA, Locust off Broad Street	4.50 up	7.50 up	7.50 up
ADELPHIA, 13th at Chestnut Street	4.50 up	7.00 up	8.00 up
ST. JAMES, 13th and Walnut Streets	3.50 up	5.50 up	5.50 up
BARCLAY, Rittenhouse Square, East	5.00 up	8.00 up	8.00 up

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager _____ Hotel, Philadelphia, Pa.

You are requested to reserve the following accommodations during the period of the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania, October 15, 16, 17, 18, and 19, 1950, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath
☐ Twin Bed Room with bath ☐ Suite

Price

Arriving _____ at _____ a.m. _____ p.m.

Departing _____ at _____ a.m. _____ p.m.

PLEASE VERIFY MY RESERVATION

Name _____

Address _____

City and State _____

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

ARE YOU REPORTING YOUR CASES?

The regulations of the Pennsylvania Department of Health require that a confidential report on each diagnosed case of malignant neoplasm be submitted to the department. Recently, every physician in the State received forms similar to the one appearing below upon which to make this report. Your cooperation in using these forms to report your cases will enable the Division of Cancer Control of the State Health Department to conduct its statistical program with increased effectiveness.

At a recent meeting, Dr. Norris W. Vaux, Secretary of Health, stated: "We are asking every physician who has a cancer case to report that case to us. We realize that there may be some duplication by having the same case reported by several doctors, but we are prepared administratively to handle such instances."

"The Commission on Cancer of The Medical Society of the State of Pennsylvania urges the cooperation of every member of the Society in this effort to have all cases reported to the Department of Health," states Dr. S. Gordon Castigliano, chairman. "Unless we as physicians cooperate, the statistical program of the Division of Cancer Control will be of little value to the health of the citizens of this Commonwealth."

REPORT OF MALIGNANT NEOPLASM

Confidential

(Regulation of Pennsylvania Department of Health requires report of each diagnosed case of malignant neoplasm)

			Date reported	
Name of patient			Occupation	
Address				
Age	Sex	Race or color	Marital	
			M .. S .. D .. W ..	
Diagnosis and primary site				
.....				
.....				
Date of first visit to you for this illness		 of first symptoms		
		 of your diagnosis		
<i>Stage at Original Diagnosis</i>				
() Localized		() Regional involvement		() Remote metastases
<i>Method of Diagnosis</i> (check one or more)				
() Clinical only		() Pathologic		() Roentgenographic
				() Cytologic
Disposition of case or where referred				
Name and address of physician reporting				
.....				

Mail completed form to the Division of Cancer Control, Pennsylvania Department of Health, Harrisburg, Pa.

A Five-Year Plan of Graduate Education

The Commission on Graduate Education has announced a new five-year program of graduate instruction designed primarily for the general practitioner. Beginning in October this course will be offered in ten strategically located centers of the State in cooperation with the medical schools of the Commonwealth.

The Graduate Education Institute will present twenty special courses in each of the ten centers during the next five years. A capable and experienced faculty will present the subject material which has been carefully outlined by special advisors to the commission. Courses will be as follows: Allergy, Bone and Joint Diseases, Cardiology, Dermatology, Endocrinology, Gastro-enterology, Genito-urinary Diseases, Gynecology, Hematology, Infectious Diseases, Interpretation of Symptoms on a Physiologic Basis, Metabolic Diseases, Neurology, Obstetrics, Parasitic Diseases, Peripheral Vascular Diseases, Physical Medicine and Rehabilitation, Psychiatry, Pulmonary Diseases, and Special Senses (Eye, Ear, Nose and Throat).

A brochure of this new program has been mailed to every member of the State Society. This booklet outlines in detail the plan of the five-year course. Abstracts of the material to be presented are given as well as a complete list of the faculty. The Commission on Graduate Education has attempted to solve the criticism of previous courses by providing a program that concentrates on only two subjects in each term.

The registration fee for the full year's program is \$25.00. Registrants will be accepted for either the fall or spring term upon payment of a fee of \$15.00. Eligible veterans may use the benefits provided in the G.I. Bill of Rights when registering for this course.

Registration may be completed by filling out the form below and mailing it with a check covering the proper registration fee to The Medical Society of the State of Pennsylvania, 230 State Street, Harrisburg.

REGISTRATION FORM

COMMISSION ON GRADUATE EDUCATION

230 STATE STREET
HARRISBURG, PA.

- ☐ Please enroll me for the entire 1950-51 program of the Graduate Education Institute at the center indicated.
- ☐ Please enroll me for the fall sessions 1950 at the center indicated.
- ☐ Please enroll me for the spring sessions 1951 at the center indicated.

Name (Last) (First name and initial)

Street and Number

City and County

Enclosed please find check for \$25.00 (full year)
15.00 (one-half year) as my registration fee.

Make checks payable to The Medical Society of the State of Pennsylvania.

Signed

*Check the Center you
expect to attend*

- ☐ Allentown
- ☐ Clearfield
- ☐ Harrisburg
- ☐ Johnstown
- ☐ Lancaster
- ☐ Meadville
- ☐ Reading
- ☐ Washington
- ☐ Wilkes-Barre
- ☐ Williamsport

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*
8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

In the interim between annual sessions, proposals for amendments or alterations to the Constitution of our Society, signed by fifteen active members of this Society, must be sent to the secretary-treasurer of the Society at least four months before the next annual session, and must be published in the JOURNAL at least three months in advance.

The Official Call for the 1950 Session will be published in the June JOURNAL. It should include all proposals for amendments or alterations, and they should be received by the secretary-treasurer not later than June 10.

ADVICE FROM ENGLAND

Lord Moran, president of the Royal College of Physicians, London, England, addressed the American Therapeutic Society after their annual banquet at the Copley-Plaza, Boston, April 15, and presented a number of interesting facets of the present system of medical practice in England.

To begin with, he pointed out that the people of England were prepared for and demanding some sort of a welfare plan by necessity—something that has not yet occurred in the United States. All political parties were advocating it; the hospitals were insolvent; something had to be done. It was useless for the doctors to oppose it. His advice to the American medical profession was to fashion the best plan possible if it ever becomes inevitable here, as it did there. (We hope it won't, and don't see why it should.)

Lord Moran himself is head of a committee, recently appointed by the Ministry of Health, to decide what specialists shall receive increased remuneration. The average specialist's income is so low that many are augmenting it by doing

other work (raising pigs, chickens, vegetables, etc.)—to the further detriment and delay in care of patients, already unheard of in this country. His committee is empowered to raise the fees for one-third of Britain's 5200 specialists. (Their incentive now becomes gaining the favor of Lord Moran and his committee.)

The general practitioner's lot is a sad one, admitted this representative of the Ministry of Health. They are "form-fillers, pill-peddlers, and the dispensers of bottles of medicine, sacrificing their professional integrity to give the patient what he wants rather than what he needs."

Cases worth while from a scientific standpoint are turned over to specialists or are sent to hospitals, and the general practitioner loses all contact with his patient. "The average general practitioner in England has not set foot in a hospital in 20 years."

His prayer and ours was clear, if not expressed, namely, that the state of medical affairs in our country, for both doctors and patients, may never approach that of our English-speaking brothers across the sea.

WENDELL B. GORDON, M.D.,
Pittsburgh, Pa.

1950 HONOR ROLL

The appended self-explanatory record on a percentage basis reflects a splendid effort on the part of county society secretaries and treasurers with an equally loyal spirit of support by more than 90 per cent of our society's entire active membership. None of the dire prophesies as to loss of AMA membership on account of the levying of dues have been realized. Of the nearly 10,000 Pennsylvanians who have paid 1950 county and state society dues, less than 7 per cent did not include AMA dues. The American Medical Association will not record them as de-

linquent if they pay the \$25 before January 1, 1951.

County	Active Mem- bers	Per Cent Paid	County	Active Mem- bers	Per Cent Paid
Adams	26	96	Juniata	7	85
Allegheny	1615	92	Lackawanna	290	88
Armstrong	44	93	Lancaster	221	99
Beaver	135	93	Lawrence	81	99
Bedford	15	54	Lebanon	74	97
Berks	244	98	Lehigh	227	92
Blair	125	88	Luzerne	381	90
Bradford	48	92	Lycoming	149	84
Bucks	93	86	McKean	50	92
Butler	67	90	Mercer	87	90
Cambria	165	90	Mifflin	37	81
Carbon	37	100	Monroe	41	92
Centre	35	97	Montgomery	348	82
Chester	125	90	Montour	38	100
Clarion	22	100	Northampton	196	97
Clearfield	46	96	Northumberland	75	95
Clinton	28	90	Perry	14	79
Columbia	46	96	Philadelphia	3193	87
Crawford	56	93	Potter	9	100
Cumberland	49	96	Schuylkill	156	86
Dauphin	251	99	Somerset	32	84
Delaware	301	93	Susquehanna	16	87
Elk	27	59	Tioga	26	85
Erie	207	95	Venango	49	90
Fayette	121	85	Warren	48	98
Franklin	80	95	Washington	140	92
Greene	25	88	Wayne-Pike	22	99
Huntingdon	29	83	Westmoreland	214	93
Indiana	42	99	Wyoming	14	84
Jefferson	62	86	York	171	96

To qualify in most specialization fields, applicants must have had, in addition to the experience specified above for the grade, a full internship in an accredited hospital in the specialized field for which they apply, or at least one year of (a) postgraduate full-time special study in the specialty in a university of recognized standing, or (b) full-time training as a resident in the specialty in a recognized institution.

Salary is based on the standard Federal work-week of 40 hours. Additional compensation is provided for any authorized overtime worked in excess of the 40-hour week. For employees whose services meet prescribed standards of efficiency, the entrance salary is increased by the amount shown in the table, following the completion of each 18 months of service, until the maximum scheduled rate for the grade is reached.

	Basic Entrance Salary	Periodic Increase	Maximum Base Salary
Grade of Position			
GS-13	\$7,600	\$200	\$8,600
GS-14	8,800	200	9,800
GS-15	10,000	250	11,000

Appointments are generally made at the basic entrance salary rate of the grade.

Send your application to the United States Civil Service Commission, Washington 25, D. C. Applications will be accepted until further notice.

OPPORTUNITIES IN GOVERNMENTAL MEDICAL SERVICE

The U. S. Civil Service Commission, Washington 25, D. C., announces examinations for MEDICAL OFFICER (Specialists) — \$7600 to \$10,000 a year (Grades GS-13 to GS-15).

The fields of medicine included number thirty-one, ranging from anesthesia through general medicine and surgery to occupational health and medicine, roentgenology, and urology.

Experience required is graded as follows:

For grade GS-13—two years of progressively responsible professional experience in the field of medicine for which they apply.

For grade GS-11—three years of progressively responsible professional experience in the field of medicine for which they apply.

For grade GS-15—four years of progressively responsible professional experience in the field of medicine for which they apply.

An internship or residency may not be included in these categories of experience.

EMERGENCY MEDICAL CALL SERVICE

Adams County

Adams County contains an estimated population of 42,000 persons and is serviced by 25 active physicians. An emergency medical call service was instituted by the Adams County Medical Society, Jan. 1, 1949. The service was given serial advertisement publicity in each of the three county newspapers. The calls are handled through the switchboard of the Annie Warner Hospital, Gettysburg, Pa., which is the only hospital located in the county.

To date, after functioning for 14 months, the service has handled 30 calls. The calls have been analyzed according to source and reason for the call.

All of the calls with about three exceptions originated in the Gettysburg area. This would seemingly indicate that the problem is more a town and city problem than it is a rural one. The necessity for such a service in our county could be eliminated if each and every physician adhered to the following rules:

1. Have the telephone covered by a responsible person when the family or secretary is away.
2. Accept due responsibility as regards night calls.
3. Arrange with fellow neighboring practitioner to accept calls when one wishes to be off duty.

Allegheny County

The Allegheny County Emergency Service has been in operation nine months. It was started in June, 1949, and since July 1, 1949, has handled 2564 emergency calls.

Method of Operation: The county has been divided into 40 telephone exchange districts; 23 of these are outside Pittsburgh, and 17 are within the city. The 17 within Pittsburgh are composed of 40 different telephone exchanges.

Emergency service is voluntary on the part of our members. At the present time we have 199 volunteers, 128 within Pittsburgh where the greatest number of calls originate. The remaining 71 doctors service the districts outside the city of Pittsburgh—where calls are negligible. Three physicians are on call in each area for a two-week period. All serve in rotation within their areas.

The Telephone Answering Service handles the actual telephone work through a special telephone number to which the society office switchboard has a tie line. The society office does all the clerical work involved. In addition to emergency calls, this commercial exchange also handles calls for referring patients to doctors and calls for information of the type which can be readily answered from an alphabetical master file. The medical society supplies the necessary files and instructions.

In eight months' time a total of 7553 calls have been handled. This includes 2564 emergency calls, 2376 referrals, and 2613 calls for information. This system costs the county society an average of \$132 per month for actual operation. Advertising and clerical costs are additional. We are handling an average of 944 calls monthly.

Although the Emergency Service started as a service to the community, it has become a service to our membership as well. Active participation in the Service is an excellent method to help young doctors establish a practice. For those physicians already established, the increased number of referrals of patients is also gratifying.

Lawrence County

An emergency call program was established in New Castle (Lawrence County) in 1948. Our community population is 50,000. The program is handled through a private telephone answering service to which a large number of our members subscribe, and this service is on a 24-hour basis. The society pays \$10 per month for the service. The calls are relayed from this agency to those physicians who have signified their willingness to accept them. Some engage in general practice; others confine their professional activities to a specialty. The number of calls from people who state that they have no physician or are unable to locate one varies from one to three per day. The operators at the board believe that the system works well. Very rarely do they have any trouble obtaining a doctor to respond. We advertise this service in the classified section of the telephone directory and it is also mentioned in a pamphlet distributed by the Welcome Wagon which contacts new arrivals in the community. Various "headaches" arise from time to time, but some are the fault of the doctors rather than the people.

1. Doctors will tell patients to call the exchange merely because they do not wish to make a certain call.
2. Doctors will be conveniently "sick" or "out of town" and throw an additional load on the service.
3. Calls to patients who are on relief sometimes become a problem.
4. Doctors fail to notify the operator as to where they may be located quickly.

In general, we feel that the problem of emergency calls has been handled satisfactorily and that definite service is being rendered to the community.

SECRETARIES-EDITORS CONFERENCE ATTENDANCE RECORD

(See "A Record Breaker," page 513.)

The societies having no representation were Bedford, Clarion, Crawford, Elk, Indiana, Northumberland, Potter, Somerset, Susquehanna, and Wayne-Pike. Of our 60 component county medical societies, 50 were represented by their president, secretary, editor, and/or committee chairmen or members, who registered as follows:

ADAMS—Samuel A. Kirkpatrick,¹ Raymond M. Hale, Jr.,² Raymond F. Sheely,³ Bruce N. Wolff,⁴ Roy W. Gifford.⁵

ALLEGHENY—Paul G. Bovard,¹ William F. Breiman,² Theodore R. Helmbold,⁵ Norman C. Ochsenhirt,⁶ Frederic W. Fagler.⁷

ARMSTRONG—Calvin E. Miller, Jr.,¹ Cyrus B. Slease,² Blaine E. Carberry,⁴ Sidney G. Sedwick.⁵

BEAVER—William T. Rice,¹ J. Willard Smith,² Donald Y. Shaffer,³ George B. Rush,⁶ John A. Nave,⁸ Kenneth M. McPherson.

BEDFORD—No representation.

BERKS—Matthew J. Boland.¹

BLAIR—Elwood W. Stitzel,¹ Arthur E. Pollock,² Roy W. Goshorn.⁴

BRADFORD—Dominic S. Motsay,² S. Paul Perry,⁴ Orlo G. McCoy.⁵

BUCKS—William I. Westcott,² Allen H. Moore,³ John F. McFadden.^{5, 6}

BUTLER—Edward C. Lutton,¹ J. Van Donaldson.²

CAMBRIA—Thomas J. Cush,¹ Joseph W. Raymond,² George Hay,³ Joseph C. Anderson,⁴ Arthur Miltenberger,⁵ Alfred G. Neill.⁸

CARBON—Marvin Evans,¹ John L. Bond,² Stanley F. Druckemiller.^{4, 5, 6}

CENTRE—John H. Light,¹ H. Thompson Dale,² John G. Weixel,⁴ John K. Covey,⁵ Hugh J. Rogers.⁸

CHESTER—Julius Margolis,¹ William C. Limberger,⁴ George W. Truitt.⁸

1. President.

2. Secretary.

3. Editor.

4. Chairman, Committee on Public Health Legislation.

5. Chairman, Committee on Public Relations or Medical Service and Public Relations.

6. Chairman, Committee on Medical Economics.

7. Executive secretary.

8. President elect.

CLARION—No representation.
 CLEARFIELD—Frances D. Taylor,¹ Ward O. Wilson,⁴ James C. Schornick.⁵
 CLINTON—Forney D. Winner.¹
 COLUMBIA—Joseph V. M. Ross,¹ Robert Klein,² Otis M. Eves,³ Jacques H. Mitrani,⁴ G. Paul Moser,⁵ Jesse G. Fear,⁶ C. Perry Cleaver.⁸
 CRAWFORD—No representation.
 CUMBERLAND—William B. Turner,¹ Richard R. Spahr,² Joseph E. Green,⁴ Creedin S. Fickel.
 DAUPHIN—Hamblen C. Eaton,² Emerson F. Fackler,³ A. S. Cobb,⁷ J. Collier Bolton,⁸ William D. Schrack, Jr., Harvey F. Smith, Park A. Deckard.
 DELAWARE—Walter E. Egbert.²
 ELK—No representation.
 ERIE—Russell B. Roth,² Carl B. Lechner,³ David D. Dunn.
 FAYETTE—Howard F. Conn,⁵ Othello S. Kough.⁸
 FRANKLIN—Paul A. Clutz,¹ Earl Glotfelty.²
 GREENE—Bruce R. Austin.⁶
 HUNTINGDON—John M. Keichline.¹
 INDIANA—No representation.
 JEFFERSON—S. Meigs Beyer.⁴
 JUNIATA—Robert P. Banks.²
 LACKAWANNA—Philip E. Sirgany,² William J. Corcoran,⁴ Martin T. O'Malley.⁵
 LANCASTER—Charles P. Stahr,² Edgar W. Meiser.³
 LAWRENCE—Mary Baker Davis,¹ Wilbur E. Flannery,^{2, 3} Charles H. Whalen,⁴ David C. Young.⁶
 LEBANON—J. DeWitt Kerr,² Harold A. Krohn.⁸
 LEHIGH—Pauline K. Wenner,^{2, 3} Robert L. Schaeffer,⁵ Charles K. Rose.⁷
 LUZERNE—Louis W. Jones,¹ Joseph W. Ehrhart,² Charles G. Perkins,³ Otto C. Reiche, Dominic D'Angelo, V. James Kennedy.
 LYCOMING—Louis E. Audet,¹ Raymond A. Davis,² LaRue M. Hoffman,⁴ Charles P. Tomlinson.⁸
 MCKEAN—Persis S. Robbins,² James E. Woodhouse.⁵
 MERCER—Michael E. Connelly,⁴ James A. Biggins.⁵
 MIFFLIN—Samuel L. Woodhouse,¹ John R. W. Hunter, Jr.²
 MONROE—Evan Reese,⁵ Charles H. Rushmore,⁵ William R. Levering.
 MONTGOMERY—Alice E. Sheppard,² Charles E. Price,³ Edwin F. Tait,⁵ Walter J. Stein.
 MONTOUR—James A. Collins, Jr.,¹ John A. Bealor,² Henry F. Hunt,⁴ Walter I. Buchert,⁶ Harry M. Klinger.⁸
 NORTHAMPTON—James B. Butchart,¹ Thomas A. Stites,² C. Hugh Bloom,⁵ Frederick W. Ward,⁶ John A. Fraumfelder.⁸
 NORTHUMBERLAND—No representation.
 PERRY—Amos G. Kunkle,¹ Frank A. Belmont.²
 PHILADELPHIA—Malcolm W. Miller,² Joseph W. Post,⁶ William F. Irwin,⁷ William W. Grim, Dorothy A. Harrison.
 POTTER—No representation.
 SCHUYLKILL—William T. Leach,¹ John C. Bryson,³ James J. Monahan,⁵ Leslie J. Schwahn.⁸
 SOMERSET—No representation.
 SUSQUEHANNA—No representation.
 TIOGA—Eleanor Larson,² Robert S. Sanford,³ Archibald Laird.
 VENANGO—Gale H. Walker.¹

WARREN—John E. Thompson,¹ John C. Urbaitis,² LeRoy E. Chapman,^{4, 6} William M. Cashman.⁵
 WASHINGTON—Raymen G. Emery,¹ Leslie J. Boone.³
 WAYNE-PIKE—No representation.
 WESTMORELAND—Russell C. Garman,¹ William E. Marsh,^{2, 3} John H. Kooser,⁴ Willis H. Schimpf,⁸ Joseph C. Griffith.
 WYOMING—Charles J. H. Kraft.⁵
 YORK—Norman H. Gemmill,¹ H. Malcolm Read,^{2, 3} Oscar A. Delle,⁴ James P. Paul,⁵ John A. Dunkelberger.⁶

State Society representatives present (not in catalogued roster of attendance) were President Samuel, President-elect Gardner, Louis W. Jones, first vice-president, Louise C. Gloeckner, second vice-president, former Presidents Borzell, Buckman, Bates, Estes, and Petry, Secretary-Treasurer Donaldson; eleven members of the Board of Trustees—Drs. Sweeney, Conahan, Hogan, Appel, Banks, Klump, Walker, Lorenzo, Whitehill, Altenuis, and Gagion; Chairman Dudley Walker, Committee on Medical Economics; Chairman Palmer, Committee on Public Health Legislation; Chairman Cowley, Committee on Public Relations; Chairman Bower, Commission on Acute Appendicitis Mortality; Chairman Smith, Commission on Graduate Education; Chairman Martucci, Commission on Physical Medicine and Rehabilitation; and Chairman Lucchesi, Commission on Preventive Medicine and Public Health. Also present were Dr. George F. Lull, Secretary, American Medical Association; Dr. Norris W. Vaux, State Secretary of Health; Dr. William S. McEllroy, dean of the University of Pittsburgh School of Medicine; Mrs. Drury Hinton, president of the State Woman's Auxiliary; Mrs. Benedict H. Birkel, president-elect of Woman's Auxiliary to Lebanon County Medical Society; Mrs. Paul C. Craig, representing AMA Woman's Auxiliary; Dr. Richard R. Hoffman, Lebanon County Medical Society; Messrs. Diller, Donley, Jenkins, Gale, Lawry, and Wray of the MSAP. Others present were Messrs. Perry, Stewart, Jansen, Brown, Richards, Hutchison, and Young of the State Society's headquarters staff.

Out of the average consumer's dollar, 4 cents goes for medical care in the United States. According to a Twentieth Century Fund report, more than half of this covers the services of doctors, dentists, nurses and others, while the rest goes for drugs, appliances, and hospitals.

PROGRESS REPORT OF COMMITTEE ON EMERGENCY DISASTER MEDICAL SERVICE

(Presented to Board of Trustees, March 2, 1950)

The Committee on Emergency Disaster Medical Service met on Feb. 25, 1950, and wishes to report that Governor Duff has appointed a new Civil Defense Committee consisting of the following members: Hon. Vincent A. Carroll, chairman, Dr. Theodore F. Distler, Dr. Ralph C. Hutchison, General Frank A. Weber, Major General Milton C. Baker, Brigadier General A. H. Stackpole, Ross L. Leffler, and Hon. Thomas McK. Chidsey.

You will note that there are *no physicians* on this committee, and we wish to present the following recommendation:

"That the Board of Trustees of The Medical Society of the State of Pennsylvania petition the Governor to add a physician to the membership of his Civil Defense Committee."

For your information, we quote a paragraph from a communication received from Judge Vincent A. Carroll:

" . . . it would be very helpful if, without any suggestion from those of us who have the responsibility of preparing the over-all plan, the medical societies of the Commonwealth would discuss this matter from the two important points, that is, medical aid and medical evacuation, and then give the Pennsylvania Civil Defense Committee the benefit of any determinations they make. . . ."

It was the consensus of the committee that efforts should be made to organize a state-wide plan and then establish district committees which would function under the chairmanship of members of this committee as follows:

ERIE District—Dr. Emerald M. Ralston
WILLIAMSPORT District—Dr. Allen J. Hannen
PITTSBURGH District—Dr. Irwin M. Pochapin
HARRISBURG District—Dr. Charles W. Smith
WILKES-BARRE-SCRANTON District—Dr. Frederic B. Davies
PHILADELPHIA District—Dr. Theodore P. Eberhard

Two other areas are not included and are of considerable importance, namely, the ALTOONA-JOHNSTOWN area and the ALLENTOWN-BETHLEHEM area. Possibly the president will wish to consider the appointment of two additional members to this committee in order that these areas may be represented.

It is the opinion also of this committee that plans for defense should be based on the defense districts suggested rather than on the basis of counties.

In organizing a state plan it is our intention to contact all states and all state medical societies in order to receive copies of their plans. Also, we hope to coordinate our efforts with those of Colonel Harold Glatly, Surgeon of the Second Army, who is in charge of this area for army medical care.

We recommend that we be permitted to proceed with our organization of the state plan and the appropriate coordination with Colonel Glatly, of the Second Army,

with the thought in mind that we shall attempt to have the plan considered and approved at the national level.

In discussion concerning blood supplies and the stock piling of bandages, it was considered appropriate that the county medical societies be informed of the approval of the AMA of the Red Cross blood bank plan. This is proposed because we recognize that at the present rate the Red Cross blood banks will be unable to cope with a serious medical disaster such as we are considering. *We suggest that a special bulletin on this subject be prepared for county medical societies in order to encourage their cooperation.*

Regarding the instruction of the profession in the medical aspects of atomic warfare, it was concluded that an effort should be made to organize programs in county medical societies for speakers on this subject. There are ample well-trained physicians in the State who are capable of presenting such programs. We, therefore, plan to use their talents in this effort and recommend that they be encouraged by the Board of Trustees to cooperate in this endeavor.

It is imperative that a survey be made in Pennsylvania in regard to the availability of medical supplies in the event of a disaster. It is the opinion of this committee that no stock piling has occurred in Pennsylvania, but this should be confirmed by an adequate investigation.

We shall appreciate the guidance and any suggestions which the Board of Trustees may have to offer to this committee.

Respectfully submitted,

THEODORE R. FETTER, M.D., *Chairman.*

SECRETARY-TREASURER'S NOTE: On March 10, 1950, Secretary-Treasurer Donaldson, as instructed by the Board of Trustees, wrote to Governor Duff who, in acknowledgment, stated that the communication had been referred to Judge Vincent A. Carroll, chairman of the Civil Defense Committee mentioned in the foregoing report. Two weeks later we were notified that Governor Duff had approved the sending of two representatives of The Medical Society of the State of Pennsylvania to Johns Hopkins University School of Hygiene and Preventive Medicine for a five-day course in atomic medicine under the sponsorship of the Atomic Energy Commission and the National Security Resources Board.

Dr. Irwin M. Pochapin, Pittsburgh, and Dr. Theodore P. Eberhard, Philadelphia, members of the state society's Committee on Emergency Disaster Medical Service, took the course and report it as having been intensive, progressively explanatory, and well amplified by instructive films.

A report, summary in character, by Dr. Irwin M. Pochapin, on this course will appear in the June issue of the PENNSYLVANIA MEDICAL

JOURNAL. It is interesting to observe that at each of the 11 graduate education centers throughout Pennsylvania in April one period was devoted to the subject of "Care and Treatment of Patients in the Event of Atomic Disaster" by Major G. M. McDonnell, Chief, Special Projects Division, Office of the Surgeon General, Department of the Army, Washington, D. C.

FOREIGN MEDICAL SCHOOL GRADUATES

Graduates of the foreign medical schools listed below are recommended for licensure consideration on an equal basis in the United States to that of graduates from U. S. approved medical schools. The list "Prepared by the Council on Medical Education and Hospitals, American Medical Association, and the Executive Council of the Association of American Medical Colleges" is not final and will be supplemented as information is compiled for other schools.

Denmark

University of Copenhagen Faculty of Medicine
(Københavns Universitet Lægevidenskabelige Fakultet)

Finland

University of Helsinki Faculty of Medicine
(Helsingfors Universitet Medicinska Fakulteten)
Medical Faculty Turku University
(Turun Yliopiston Lääketieteellinen Tieðekunta)

Netherlands

University of Amsterdam Faculty of Medicine
(Universiteit van Amsterdam Geneeskunde Faculteit)
Royal University of Groningen Faculty of Medicine
(Rijks-Universiteit te Groningen Medische Faculteit)
Royal University of Leiden Faculty of Medicine
(Rijks-Universiteit te Leiden Faculteit der Geneeskunde)
Royal University of Utrecht Faculty of Medicine
(Rijks-Universiteit te Utrecht Faculteit der Geneeskunde)

Norway

University of Oslo Faculty of Medicine
(Kongelige Frederiks Universitet Medisinske Fakultet)

Sweden

Royal Charles University Medical Faculty, Lund
(Kungl. Karolinska Universitetet Medicinska Fakulteten)
Charles Medico-Surgical Institute, Stockholm
(Karolinska Mediko Kirurgiska Institutet)
Royal University of Uppsala Medical Faculty
(Kungl. Universitetet i Uppsala Medicinska Fakulteten)

United Kingdom

England

University of Birmingham Faculty of Medicine
University of Bristol Faculty of Medicine
University of Cambridge Faculty of Medicine
University of Durham Medical School, Newcastle upon-Tyne
University of Leeds Faculty of Medicine
University of Liverpool Faculty of Medicine
University of London
University of Manchester Faculty of Medicine
University of Oxford Faculty of Medicine
University of Sheffield Faculty of Medicine

Northern Ireland

Queen's University of Belfast Faculty of Medicine

Scotland

University of Aberdeen Faculty of Medicine
University of Edinburgh Faculty of Medicine
University of Glasgow Faculty of Medicine
University of St. Andrews Medical School, St. Andrews and Dundee

Wales

Welsh National School of Medicine, University of Wales, Cardiff

—*Journal A.M.A.*, Feb. 25, 1950.

COMPULSORY HEALTH INSURANCE UNPOPULAR

DEAR DOCTOR:

Compulsory health insurance is far from popular among the city folk, according to a survey just completed by the Psychological Corporation, New York, in 25 cities and towns from coast to coast.

They asked the question:

"Which do you favor: (a) to have the government give free doctor and medical service which would be paid for by a 3 per cent payroll tax on all wages under \$3,600, or (b) the present system of medical service?"

65% favored the present medical service
26% favored government medicine
9% were uncertain

Even in the lower income group, the lowest third which is supposed to benefit most from government medicine, 51 per cent were against the plan while 37 per cent favored it.

In an April, 1947 survey on what people consider good and bad Americanism, the following question was asked:

"Which is better for America: (a) to have the government give free doctor and medical service which would be paid for by a tax like the Social Security tax; or (b) the present system of medical service?"

63% favored the present medical service
30% favored government medicine
7% were uncertain

Insofar as the two questions and surveys are comparable, it would seem that, in spite of the heavy government propaganda in favor of socialized medicine, there has been little change in the proportion of people who favor government medicine.

The Psychological Barometer, started by Dr. Henry C. Link in 1932, is the oldest periodic poll of public opinion and buying habits in existence. The present survey was made by 81 interviewers working under the direction of 22 psychologists associated with the Psychological Corporation.—Excerpt from AMA Secretary George F. Lull's Letter No. 141, March 27, 1950.

PENNSYLVANIA HEALTH COUNCIL BY-LAWS

ARTICLE I.—NAME

The name of this organization shall be the Pennsylvania Health Council.

ARTICLE II.—OBJECT

SECTION I.—The objective of the Council shall be to assist in coordinating as far as possible the planning and activities of all agencies concerned with community health; to study health needs of the Commonwealth by means of appropriate survey, inventories, and fact-finding activities and to stimulate public interest in health needs and their solution; to help develop and promote

constructive health programs; to propose constructive and needed legislation and to work for its enactment into law; to work cooperatively with local health councils; and to work to prevent and eliminate overlapping and duplication of community health efforts.

SECTION 2.—It is understood that action by the Council does not (and in many cases cannot) bind the member organizations in their own policy or to the details of a program. It is a clearinghouse and coordinating, not a directing body. Neither is it set up to duplicate staff and become an operating body in competition with functions now performed by member organizations.

ARTICLE III.—MEMBERSHIP

SECTION 1.—The membership shall include state-wide organizations active in health fields, including official health agencies, voluntary health agencies, professional organizations, and others representing various groups of citizens with active concern in the health fields.

SECTION 2.—Any organization wishing to become a member of the Pennsylvania Health Council shall make formal application for consideration and action by the Membership Committee and by the Executive Committee, which shall take final action on all applications.

SECTION 3.—Each organization shall have one representative and one alternate as members of the Council and be entitled to one vote.

SECTION 4.—In case the president of the Pennsylvania Health Council shall be one of the delegate members, the organization he represents shall have the privilege of an additional delegate with voting power.

SECTION 5.—Each organization shall as a condition of membership keep the Council advised as to its program.

ARTICLE IV.—OFFICERS

SECTION 1.—The officers of the Council shall be a president, a first vice-president, a second vice-president, a secretary, and a treasurer.

SECTION 2.—The officers and the Executive Committee shall be elected annually at a meeting of the Council to be held at a time and place to be designated by the Executive Committee and they shall hold office until their successors are elected. No officer may serve more than three consecutive terms.

SECTION 3.—At least eight weeks previous to the annual meeting the president shall appoint a nominating committee of five members which shall prepare a list of two nominees for each of the offices to be filled by election. The names of such nominees shall be submitted to the membership with notice of the meeting, which shall be mailed to all member agencies at least one month previous to the meeting date.

SECTION 4.—Vacancies in any office due to death, resignation, or other cause shall be filled by a vote of the Executive Committee. The person so elected shall remain in office until his successor is duly elected at the next annual meeting of the Council.

SECTION 5.—The duties of the president shall be to preside at all meetings of the Council and of the Executive Committee, unless he shall designate a vice-president or other delegate to preside in his stead. The president shall be ex officio a member of all standing committees, and shall have such powers of supervision and management as may pertain to the office of president or shall be assigned by the Executive Committee.

SECTION 6.—The duties of the vice-presidents shall be, in event of absence, disability, or death of the president, to exercise the powers and perform all the duties of the office. The vice-presidents shall perform such other duties as the president and Executive Committee may assign.

SECTION 7.—The duties of the secretary shall be to keep minutes of all meetings of the Council and committees; to issue all calls and prepare, in cooperation with the president, agendas for meetings; to keep a record of the Council membership; to collect dues and other payment due the Council; to supervise the balloting at all elections and to perform such other functions as may be incidental to the office or assigned by the Executive Committee.

SECTION 8.—The duties of the treasurer shall be to have custody of all funds of the Council and to make withdrawals of funds only by check and on written authority of the Executive Committee. The treasurer and any employee handling funds of the Council shall be adequately bonded at the expense of the Council.

ARTICLE V.—SESSIONS AND MEETINGS

SECTION 1.—The Council shall meet at least once a year, the time and place to be designated by the Executive Committee. Special meetings of the Council shall be called by the president at the written request of at least 25 per cent of the membership.

SECTION 2.—The Executive Committee shall meet at least every three months and additionally at the call of the president, who shall designate the time and place.

SECTION 3.—All committees shall meet at the call of their chairman, the time and place to be designated by him; and the chairman shall call a meeting on the request of the majority of members of any committee.

SECTION 4.—A quorum for the transaction of business of the Council shall consist of one-quarter of the members. A majority of members shall constitute quorums for meetings of the Executive Committee and of standing and special committees.

ARTICLE VI.—COMMITTEES

SECTION 1.—*Executive Committee.* The elected officers of the Council, together with the chairmen of all standing committees plus five members elected at large from the Council, shall constitute the Executive Committee. The committee shall be responsible for supervising the Council's program and administrative activities and shall perform such other duties as may be assigned it by vote of the Council. The Executive Committee shall consult with the Council as a whole where the establishment or change of a major Council policy is concerned. This may be done at a meeting or by referendum. A majority of the Council will be required to establish or to alter a major Council policy.

SECTION 2.—*Standing Committees.* The following standing committees to consist of five members each shall be appointed by the president: (1) Membership, (2) Program, (3) Budget and Finance, (4) Public Relations and Education. The committee members shall hold office for one year, or until their successors are appointed. Each committee shall elect its own chairman.

SECTION 3.—*Special Committees.* The president may appoint special committees on authority of the Council or Executive Committee.

SECTION 4.—All committees shall be responsible to the Executive Committee.

ARTICLE VII.—FUNDS

The annual contribution required from members to the Council shall be recommended by the Executive Committee and be decided by the Council.

ARTICLE VIII.—FISCAL YEAR

The fiscal year of the Council shall be the calendar year.

ARTICLE IX.—AMENDMENTS

These by-laws may be amended at any regularly scheduled meeting of the Council by a majority vote, provided notice, with wording of proposed amendment, has been given at least one month in advance to all Council members or has been announced at a previous Council meeting. Amendments may be submitted by any five members to the Executive Committee for approval and submission to the Council.

EXCERPTS FROM MINUTES OF BOARD OF TRUSTEES MEETINGS

March 2, 1950

The Board of Trustees of The Medical Society of the State of Pennsylvania met on Thursday, March 2, 1950, in the Governor's Room at the Penn-Harris Hotel, Harrisburg, Pa.

Members in attendance were: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; Malcolm W. Miller, assistant secretary-treasurer; and Louise C. Gloeckner, second vice-president.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Allen W. Cowley (Public Relations), Dudley P. Walker (Medical Economics), Pascal F. Lucchesi (Preventive Medicine and Public Health), John O. Bower (Acute Appendicitis Mortality), Howard K. Petry, and Messrs. Lester H. Perry, executive secretary, A. H. Stewart, Jr., convention manager, Leo E. Brown, executive assistant, and Robert L. Richards, staff secretary, all of the Harrisburg office. Dr. George F. Lull, secretary of the American Medical Association, was also present.

Chairman Klump called the meeting to order at 9:15 a.m. and introduced Dr. George F. Lull, secretary and general manager of the American Medical Association.

The minutes of the Dec. 8 and 9, 1949 meetings were approved as corrected.

Finance Committee: Chairman Whitehill read his report, incomplete as of February 28 because bank bal-

ances were not available in the Secretary-Treasurer's office at the time the report was prepared.

Publication Committee: No report.

Building Maintenance Committee: Chairman Conahan reported that the remodeled second and third floors of the building at 226 State Street would be ready for occupancy in April or May. Expenditures to date totaled \$17,808. The report was accepted.

The report of the *Library Committee* as distributed by mail was accepted.

Medical Defense Cases: A report was given on case No. 372. The verdict after three days' trial, with the jury out 15 hours, assessed damages of \$65.

Report of President Samuel: Dr. Samuel read a letter that he as president had written to the Medical Service Association of Pennsylvania commending it on the fine results attained.

It was moved (Dr. Altemus), seconded (Dr. Lorenzo), and unanimously carried that the Secretary write a congratulatory letter to the Medical Service Association of Pennsylvania in the name of the Board of Trustees.

At the suggestion of President Samuel, who had been invited to attend the Founder's Day dinner of the Woman's Medical College on March 10, 1950, the Board instructed the Secretary to write a congratulatory letter to the Woman's Medical College of Pennsylvania on its one hundredth anniversary.

President Samuel referred to a communication addressed to the Columbia County Medical Society regarding their resolution asking that the Pennsylvania delegates to the AMA meeting in June, 1950, be instructed in presenting a resolution criticizing the management of hospitals who refuse staff privileges to licensed doctors of medicine.

Dr. Samuel stated that the Pennsylvania State Nurses Association had drawn up a bill for the 1951 Legislature which would qualify all nurses under the State Nurses Practice Act, and which they would like the State Medical Society to support. This request was referred to the Committee on Public Health Legislation.

President Samuel advised that he had appointed Dr. Norman R. Ingraham, Philadelphia, as chairman of the Commission on Syphilis and Venereal Diseases to succeed Dr. Samuel L. Grossman, who had resigned on account of ill health. He also commented on the chairmanship of the Committee on Public Relations now held by Dr. Allen W. Cowley, who will serve until October, 1950. He succeeded Dr. Howard K. Petry who had resigned as chairman because of ill health but who is remaining as a member of the committee.

The recently appointed chairman of the Commission on Nutrition is Dr. Michael G. Wohl, Philadelphia, and the representative of the State Society on the State Poliomyelitis Planning Committee is Dr. Wilton H. Robinson, Pittsburgh.

Dr. Samuel also stated that the vacancy in the Commission on Nutrition, caused by the resignation of Dr. Stanley D. Conklin, had been filled by Dr. Paul L. Shallenberger, of Sayre.

On motion the report of President Samuel was received.

Report of Secretary-Treasurer

SECRETARY DONALDSON: You all received earlier a copy of my report. When written on February 24, it reported a very favorable return of dues, 5388 members having paid dues in full. Three days later the total received had grown to more than 7000. Of the 6511 processed, less than 5 per cent of the members have not included the AMA dues.

Originally there was considerable talk about many members resigning because of the high dues. We have had 24 resignations, mostly from members who have moved from the State or who hold Service Fellowship in the AMA because of their connection with governmental services, including the VA.

DR. GEORGE F. LULL: That is a splendid report. We have had only two resignations sent directly to us. We in the AMA look for the over-all membership loss in the United States to be 12 to 15 per cent. This may result in loss of delegate apportionment in some state societies.

SECRETARY DONALDSON: For delegate apportionment purposes, do you count the associate members who do not pay dues or hold office?

DR. LULL: We accept the membership reported by the state societies. They are supposed to be active dues-paying members only.

SECRETARY DONALDSON: Dr. Lull, I assume that every member of The Medical Society of the State of Pennsylvania as of Dec. 31, 1949, continues as a 1950 member of the AMA and will not become delinquent until the end of 1950.

DR. LULL: If his dues are not paid by the end of 1950, he will be notified that he has been dropped.

SECRETARY DONALDSON: In my report I mentioned studies of the "Keystones of Public Health," hoping that you would be impressed by my opinion that you are not going to be able to give it adequate consideration at this meeting.

CHAIRMAN KLUMP: As to the report of the Secretary-Treasurer, I have a comment on the last paragraph under the section headed "Keystones of Public Health." Dr. Lucchesi and I requested an audience with the Secretary of Health, but we have been unable to arrange such an audience.

SECRETARY DONALDSON: We are publishing a series of guest editorials in the JOURNAL based on "Keystone" reports approved by our Commission on Preventive Medicine and Public Health, and a copy of each in printer's proof has been sent to Secretary Vaux inviting him to comment for the benefit of the readers of the JOURNAL.

DR. GAGION: I would like to report what they have done in Luzerne County on "Keystones of Public Health." An over-all steering committee has been appointed with Dr. Buckman and myself as medical representatives. We will take the Luzerne County section of the report and break it down for study by subcommittees. Later this over-all committee will abstract and epitomize these reports and bring out recommendations from Luzerne County.

Chairman Klump called the attention of the Board to the gift of \$1,000 from Dr. Elmer Hess to the Society's Educational Fund. The Secretary was requested to write a letter of thanks to Dr. Hess on behalf of the State Society.

CHAIRMAN KLUMP: Do you want to say anything about the Columbia County letter referred to by President Samuel?

SECRETARY DONALDSON: I think that a copy of our reply should be sent to every county society that received the Columbia County Society proposed resolution on "hospitals that exploit physicians."

The report of the Secretary-Treasurer was accepted.

Report of Executive Secretary

MR. PERRY: In addition to the items contained in my mimeographed report, there came to my attention a letter from the Brookings Institute. They are embarking on another study of the availability of medical service in the United States. The meat of this letter which I received is contained in this sentence: "At present we would like to know whether or not the state medical societies would be in a position to furnish any data on state levels as found in the outline under Section 2, 'Medical Personnel and Facilities.'" This outline occupies 10 pages. We do not have in our possession at this time the data that they are seeking about medical personnel and facilities in Pennsylvania, and we don't have the facilities to obtain this information. They will have a survey staff with which we will cooperate to the best of our ability.

The report of the executive secretary was accepted.

The report of the convention manager was accepted as circulated.

Report of Committee on Public Health Legislation

CHAIRMAN PALMER: The Superintendent of Public Instruction has instructed the Attorney General's office to study the constitutionality of the act creating a Board of Chiropractic Examiners. Our committee approved of helping the Attorney General's office in this study.

It was moved (Dr. Gagon), seconded (Dr. Whitehill), and unanimously carried that this recommendation of the Committee on Public Health Legislation be accepted.

DR. PALMER: Miss Alice O'Halloran, of the Department of Health, is recommending the development of a memorial to the late Dr. Samuel C. Dixon, the first qualified state secretary of health. The department will probably help with the expense.

The matter of a memorial for Dr. Samuel C. Dixon is to be studied by the Committee on Public Health Legislation for report to the Board of Trustees at its May Meeting.

The Board adopted the suggestion of the Committee on Public Health Legislation to present an appropriate citation of appreciation to the two doctors currently serving in the Pennsylvania Legislature—Drs. Leroy E. Chapman (Senate) and George J. Sarraf (House).

The report of the Committee on Public Health Legislation was accepted.

Report of Committee on Medical Economics

CHAIRMAN DUDLEY WALKER: The committee has not met. Dr. Donaldson has alerted your chairman to the possibility that a situation may develop in the western part of the State due to the lack of funds in the United Mine Workers Health and Welfare Fund, and that physicians in several counties held meetings to discuss the matter. Fortunately, they have remembered that the State Society Committee on Medical Economics a year ago discussed the matter at meetings with medical representatives of the Health and Welfare Fund and had advised at that time that no state-wide fee schedule be set. Our committee invites any of our county groups concerned to ask us to hold conferences with them on any problems that come up.

President Samuel has suggested that our committee ask for sufficient funds to make a thorough study of the State's well-baby and venereal disease control clinics to learn how much of the taxpayers' money they spend serving people who are able to pay for such professional service. Perhaps some of the information that Dr. Samuel seeks has been obtained in the Keystones of Public Health survey; however, the committee will wait for instructions.

DR. KLUMP: The appropriate committee or commission involved has been studying these situations as contained in "Keystones of Public Health" and such reports will be brought to your attention today. Whether they will answer Dr. Samuel's question, I cannot say.

The matter of well-baby and venereal disease control clinics was referred to the Committee on Medical Economics for further study.

DR. KLUMP: In connection with the report of the Committee on Medical Economics, I call attention to Dr. Palmer's report (first page) in which he alerts us to the fact that "health rooms" and "on-the-job health services" are being suggested for Federal employees, also his statement, "We may again be faced with the creation of a fee schedule." I would suggest that the Committee on Medical Economics just bear it in mind, and I hope that they will consult with former Chairman Jones if faced with the creation of still another fee schedule.

The report of the Committee on Medical Economics was accepted.

Report on Pennsylvania Health Council

DR. PALMER: You have a copy of the action taken at the last meeting and the names of the officers elected. There are only two recommendations. One is that this Board select a delegate and an alternate to this organization and the other is to pay a fee of \$25 as a contribution to the organization.

Dr. C. L. Palmer was elected as delegate to the Pennsylvania Health Council and Dr. Charles V. Hogan was named the alternate. Payment of the organization fee of \$25 was authorized.

Report of Commission on Acute Appendicitis Mortality

Dr. John O. Bower, chairman, distributed copies of a progress report by his commission. In addition to the report, Dr. Bower elaborated upon the need for and

the use of "de-shocking rooms" in hospitals. He also displayed charts concerning appendicitis mortality statistics to supplement the survey made by his commission.

DR. SAMUEL: To what extent did Secretary of Health Vaux pledge financial cooperation?

DR. BOWER: I take it that Dr. Vaux is willing to meet us halfway and perhaps more in the way of sponsoring this program.

CHAIRMAN KLUMP: This recommendation suggests that we alert the hospitals to a program in which certain teaching will be done and also that we cooperate with the Secretary of Health in an educational program.

The report of the Commission on Acute Appendicitis Mortality was accepted.

Report of Committee on Public Relations

Dr. Kiump presented to the Board the new chairman of the Committee on Public Relations—Dr. Allen W. Cowley of Harrisburg, who reviewed his committee's report as previously distributed.

I. Transfer of committee chairmanship—informatory.

II. National Education Campaign conference in Chicago, Feb. 12, 1950.

DR. PALMER: As I read Mr. Clem Whitaker's paper presented at this conference, I could see that apparently the issue is whether or not this Board wants to authorize a transfer of certain activities that traditionally have been in the hands of the Committee on Public Health Legislation to the Committee on Public Relations.

Dr. Palmer then briefly presented a résumé of the mimeographed report which he had prepared regarding "political action committees."

MR. BROWN: Mr. Whitaker's remarks were authorized by the Board of Trustees of the AMA and the Coordinating Committee operating the present educational campaign. The only concern of the Public Relations Committee which has been delegated to promote the AMA national education campaign in Pennsylvania is with that portion of its 1950 program which overlaps the responsibilities of the Public Health Legislation Committee. Our committee seeks the guidance of this Board and its suggestions as to whether or not it should continue to promote the National Education Campaign as handed down by Whitaker and Baxter, or shall that portion dealing with legislation be referred to the Public Health Legislation Committee? We are concerned from a public relations standpoint with the danger that county societies may violate the Hatch Act, as pointed out by the attorneys consulted by Whitaker and Baxter (see page 275, March PENNSYLVANIA MEDICAL JOURNAL). Under such violation certainly our public relations program would be affected, and we are anxious that each county medical society become familiar with any restrictions imposed upon them as an organization. We primarily are interested in your counsel and suggestions and decision as to how and to whom this portion of the National Education Campaign should be allocated.

DR. GAGON: I believe our policy should be guided entirely by this one sentence in the report: "We sug-

gest that each committee stay within its own scope of activity." I believe that all matters pertaining to legislation should be entirely and solely the province of the Committee on Public Health Legislation.

It was moved and seconded that our interest and policy in public affairs be guided by the policies laid down in the report of Chairman Palmer of this date which is captioned "statement regarding political action committees."

Chairman Klump relinquished the chair to Dr. Gagon in order to discuss this motion.

DR. KLUMP: I would remind the Board that we have a special committee appointed by the President which is currently studying our society's committee structure. That report will not be before us until the next meeting. I would also remind you of the AMA's approval of this. Before they had their special Education Campaign Committee, this was largely the whole problem of the Council on Public Relations and Medical Service, and even legislation was under the Council on Medical Service, although they have a special legislative committee. The AMA does not approve legislative candidates individually. My own view is that with a sound public relations job done the work of a Public Health Legislation Committee is very much helped. We should definitely advise and emphasize to our county societies the fact that "political action committees which lend their support to candidates for office must be independently organized by individual doctors. They cannot in any sense be subsidiaries of the medical societies." That would apply equally to Dr. Palmer's committee. We are in just as much danger there. I would agree with your motion that definite legislative matters be referred to that committee, but its public relations angle is so broad that we must not curtail the actions of our Public Relations Committee; and with proper coordination and cooperation that could not happen.

MR. BROWN: Should our field men be instructed to carry this message of warning regarding illegal political activities to the county societies as they speak before them, or should they not mention it?

DR. PALMER: We have already proclaimed such warnings. We have always been guided by the election laws. I agree with you that public relations is an important phase, particularly at this time, but my experience has taught me that you have to get your letters and telegrams directly into the hands of the legislators.

MR. BROWN: Am I to understand from the Board of Trustees that our public relations activities will not go into anything whatsoever dealing with public health legislation or the warning to county medical societies?

DR. GAGON: As I read this report, Mr. Whitaker is proposing the same thing that Dr. Palmer has advised us to do in every political campaign. We want to go to these candidates and say, "This is our attitude."

DR. APPEL: I am in favor of the motion, but I would like to know if there would be any difficulty involved by the splitting of the contact between Whitaker and Baxter and the two committees in Pennsylvania. In other words, should Whitaker and Baxter contact the Public Relations Committee and they in turn contact

the Public Health Legislation Committee, or could it be arranged that Whitaker and Baxter contact both committees?

DR. LULL: From what I have heard the Corrupt Practice Act and the Hatch Act have nothing to do with the activities of the AMA or of you in supporting certain legislation after it is introduced. The Corrupt Practice Act and the Hatch Act have to do with your organizational political activities for or against candidates for election. You cannot as a society go out to work for a candidate. As to public health legislation or public relations, the organization of many state societies differs, but as long as Whitaker and Baxter know with whom they are to deal, it will be satisfactory. Coordination has to be carried on at the state level.

The motion under discussion was unanimously carried.

III. Education Campaign committee conferences.

DR. COWLEY: The date of the first conference is March 30 and it will be held in Johnstown. The total expense is to be met from the budget of this committee.

This section of the report was accepted.

IV. Benjamin Rush county awards.

This section of the report was accepted and the appointments recommended were authorized to be made.

V. Reactivation of County Society D.P.A. Committee.

This section of the report was accepted.

Dr. Cowley then reported on a conference of the Eastern Central Labor Union Educational Institute which will be held in Wilkes-Barre on April 21, 1950. At that time Dr. John Conlan, Public Information Director of the Massachusetts State Medical Society, will present medicine's viewpoints on sickness insurance. He will be opposed by Mr. Nelson Cruikshank of the American Federation of Labor.

Dr. Cowley also reported on a state-wide conference of the American Federation of Labor to be held in Harrisburg on April 4, the individual to present medicine's viewpoint to be chosen at a later date.

The remainder of the report of the Committee on Public Relations was informative. The report was accepted as a whole except as affected by the previous adoption of Dr. Gagon's motion.

Report of Commission on Preventive Medicine and Public Health

Chairman Klump requested Vice-chairman Gagon to assume the chair in order that he might take part in the discussion.

CHAIRMAN LUCCHESI: Briefly, I want to review some of the things that we have done since our last report. You authorized the commission to purchase 300 additional copies of the Public Health Survey. Recently I have received a communication from the Pennsylvania Citizens Association and the Pennsylvania Tuberculosis Society, who are having 1000 copies made, that the approximate cost will be about \$2.10 exclusive of the mailing. They have asked if it is possible to have the money in advance. They wanted to know if we could pay for the 300 copies before we receive them.

Secretary Donaldson advised Dr. Lucchesi that that request was approved by the Board of Trustees at its last meeting and that this advance payment can probably be made. (It was so agreed.)

DR. LUCCHESI: You also approved in principle a digest of a digest. Since then I have received a copy. It is a small booklet and will cost about 5 cents a copy. (It was later quoted at about 3 cents a copy.) At the last meeting we were authorized to take part in this venture and then when it was adopted bring it back to you for action. I have read it carefully and see nothing controversial in it.

The guest editorials on sections of the "Keystones" survey report appearing in the JOURNAL have all been approved by the commission and sent to Editor Donaldson. We also sent copies to Dr. Vaux.

Our various commissions and committees have delivered their reports on the various "Keystones" and we met last month and were able to go over them and add certain recommendations. You have in this Progress Report a good many of them. In general they include, first, Appendix A—a chapter on local health services. Actually this was approved previously by the House of Delegates. If we approve that as it is in toto, we are really accepting at least five of the keystones of public health that are recommended in this report. Our commission recommends that Chapter A be approved.

DR. KLUMP: I made a presentation before the commission regarding Chapter A, and in addition to the documentation in the survey I offered several other items of documentation including two editorials from the *Journal of the AMA*, the statement of Dr. James R. Miller before a Senate subcommittee, point 6 of the 12-point AMA program, etc. I have further documentation here if that be needed. Inasmuch as local health units have been approved by the AMA and the "keystone" dealing with that has been approved by the House of Delegates, I am wondering if you consider that sufficient documentation to go ahead with the approval of Chapter A.

Chapter A (local health services) of the Public Health Survey was adopted, as was Chapter B (Department of Health) and Chapter C (fiscal administration) after deleting the remark following the quotation contained in point 12. Appendix B of the Progress Report (re Chapter G of the Survey) was adopted, as was Appendix C of the Progress Report (re Chapter K).

DR. KLUMP: In the "Keystones" report by the Society's Commission on Tuberculosis, as our commission received it, this appeared: Dr. M. Clay Stayer made a presentation before them, following which "the Commission on Tuberculosis of the MSSP voted unanimously to commend Dr. Stayer for his efforts to date in the program of the State Bureau of Tuberculosis Control, and it concurs in general with his objectives as outlined at the Jan. 14, 1950 meeting of the commission." This should be noted by our Board.

On motion the action of the Commission on Tuberculosis regarding the work of the State Bureau of Tuberculosis Control was received and made a part of the minutes.

Appendix D of the Progress Report (re Chapter L of the Survey) was approved.

Discussion Regarding Appendix E of the Progress Report

Dr. Palmer called attention to Act 343 of the 1945 Legislature and advised that, if this is adopted, Act 343 will have to be repealed.

DR. JONES: I am strongly opposed to Recommendation 7 until the Luzerne County Division has had a chance to complete a survey and make a report to this Board. How many orthopedic men were consulted before this was approved by the Commission on Physical Medicine and Rehabilitation?

Dr. Lucchesi called attention to Recommendation 4 on page 2 of Appendix E.

On motion, Appendix E of the Progress Report (re Chapter R of the Survey) was re-referred to the Commission on Preventive Medicine and Public Health for further study and subsequent recommendation to this Board.

Appendix F of the Progress Report (re Chapters T and U of the Survey) was adopted.

Appendix G of the Progress Report (re Chapters P and Q of the Survey) was approved as published.

Letter from Dr. Hubley R. Owen

Dr. Lucchesi then distributed copies of a letter dated Feb. 14, 1950, from Dr. Hubley R. Owen regarding the reporting of communicable diseases. He stated that the Commission on Preventive Medicine and Public Health recommended approval of the proposed transfer to the proper authorities. This was approved.

Recommendation of Commission on Industrial Health and Hygiene

Chairman Klump then read the following recommendation submitted by the Commission on Industrial Health and Hygiene:

"that inasmuch as the State Society is not equipped with a group pointing the attention of physicians to the growing importance of the geriatrics problem, this matter be brought to the attention of the Board of Trustees, who might consider it sufficiently important to remand it to the Committee on Scientific Work for the benefit of all the members of the Society."

Secretary Donaldson reported that the 1950 Scientific Work Committee had been so informed.

At 1:05 p.m. the meeting adjourned to reconvene March 3, at 12:30 p.m.

GEORGE S. KLUMP, M.D., *Chairman*,

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*.

March 3, 1950

The Board of Trustees reconvened Friday, March 3, 1950, after lunch, in the American Room at the Penn-Harris Hotel, Harrisburg, Pa.

Members in attendance were: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagion (12th).

Officers present were: Drs. E. Roger Samuel, pres-

ident; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Louise C. Gloeckner, second vice-president.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Dudley P. Walker (Medical Economics), Albert A. Martucci (Physical Medicine and Rehabilitation), Charles Wm. Smith (Emergency Disaster Medical Service), George F. Lull, secretary of the American Medical Association, and Messrs. Lester H. Perry, executive secretary, Robert L. Richards, staff secretary to the committees, and Leo E. Brown, executive assistant.

Chairman Klump called the meeting to order at 1:45 p.m.

Report on "ACES"

Prior to Dr. Gardner's report on Americans for the Competitive Enterprise System, Inc. (ACES), in Dr. Engel's absence, Secretary Donaldson read a letter from Dr. Engel regarding this organization.

DR. GARDNER: Several weeks ago I received a letter from Mr. George Whitwell, general sales manager for the Philadelphia Electric Company, who was a moving spirit in the organization of ACES. He interested Dr. Engel and you know the story from there. The president of the Duquesne Light Company, Pittsburgh, called together several Pittsburgh industrialists at a luncheon at the Duquesne Club. They turned out 100 per cent. (Named prominent industrialists and others who attended.) There was some lukewarm discussion after Dr. Distler and Mr. Winsor presented the aims of the organization, and the meeting closed by making Judge Charles E. Kenworthy, Pittsburgh, a former Philadelphia attorney, chairman of a committee that he is to appoint from those who were at the luncheon. This committee is to investigate the possibility of developing ACES in the Pittsburgh area.

DR. GAGION: This report may be a warning to us to go a little slower than we usually do.

Date and Place of 1950 Councilor District Meetings

FIRST	March 29	Philadelphia
SECOND	May 10	Reading
THIRD-FOURTH		
combined	April 13	Bethlehem
FIFTH	May 18	York
SIXTH	May 18	State College
SEVENTH	May 3	Williamsport
EIGHTH	June 14	Union City
NINTH	June 15	Punxsutawney
TENTH	June 8	Pittsburgh
ELEVENTH	June 8	Washington
TWELFTH	June 21	Dallas

Chairman Klump reported that Mrs. Hinton, state president of the Woman's Auxiliary, had brought to his attention the fact that she had requested that councilor district meetings be arranged somewhat consecutively so that officers of the Woman's Auxiliary might better be able to attend them.

Secretary Donaldson was instructed to correspond with Mrs. Hinton regarding this matter. (SECRETARY'S NOTE: Mrs. Hinton has been fully informed.)

Request of Dr. Paul C. Craig

CHAIRMAN KLUMP: Last September we received a lengthy communication from Dr. Craig and put consideration of it off until a future meeting.

SECRETARY DONALDSON: The Scientific Work Committee at its January meeting gave recognition to the "study club" feature of that program as suggested by Dr. Craig, and on Thursday afternoon during the 1950 Philadelphia session the entire afternoon will be given over to "study clubs" to be arranged by the various scientific sections under the guidance of Dr. Craig.

Veterans Loan Fund

CHAIRMAN KLUMP: The former chairman of the Veterans Loan Fund—Dr. Gibson of Williamsport—gave me a memo reminding us of the provisions of the Veterans Loan Fund. He states that the 10 per cent deducted was to be kept by The Medical Society of the State of Pennsylvania as a central fund from which deserving members from small societies could receive a loan upon approval, and that it also was to be kept for an indefinite time to be used as a special fund from which to meet future catastrophic needs of veterans and their families.

SECRETARY DONALDSON: We did make one \$500 loan to a veteran from a small society that had accumulated only \$35. I mentioned in my report of yesterday that the disposition of the 10 per cent reserve might better be discussed at this Board's May or July meeting.

Report of Committee to Study Grievance Committee Project (Copy distributed. See April PMJ, page 396.)

CHAIRMAN JONES: Paragraph 1 is a repetition of what we told you at the meeting yesterday. Paragraph 2 is a repetition of the experience with grievance committees in Colorado.

DR. SWEENEY: In the past, censors at the county society level functioned satisfactorily, so that complaints didn't go any further. The solution is that such complaints go through an active board of censors in each county society.

DR. GAGION: I don't approve of the publicity involved. I think we have the machinery set up to take care of complaints where they arise.

DR. HERMAN WALKER: I agree with Dr. Gagon.

DR. JONES: We are not at present recommending a Grievance Committee; we are merely proposing for the public a more clear-cut and definite right and avenue of appeal.

SECRETARY DONALDSON: I should remind you that by instruction of this Board of Trustees we have already requested all our county medical societies to be discussing this grievance committee idea. Throughout the discussion during the Conference yesterday the thought was left with 200 county society representatives that they were to go home and to encourage thinking this project through and to advise their delegates before the House meets next October.

On motion the last paragraph of the report of the special committee to study a grievance committee project was adopted, and the committee instructed to pre-

pare a resolution to amend the by-laws (Sect. 3, Chap. IV) by inserting the words "*or by the public*" after the words "by a member." The last paragraph referred to reads as follows: "We recommend that the Board continue this committee for further study of this question, and that this committee be given permission to disseminate to the county medical societies factual information and reports of the experience of this and other states in the handling of this problem."

*Report of Commission on Emergency Disaster
Medical Service*

Dr. Charles Wm. Smith presented this commission's report at the request of the chairman, Dr. Theodore R. Fetter (see page 527, this issue).

The report of the Committee on Emergency Disaster Medical Service was accepted.

*Further Discussion Regarding the Progress Report
of the Commission on Preventive Medicine
and Public Health*

On motion the Board's action of March 2 regarding this committee's report was *rescinded*.

On further motion adopted the report of the Commission on Preventive Medicine and Public Health is to be the first order under "Unfinished Business" at the May meeting of the Board of Trustees.

Report of Commission on Mental Hygiene

This report, read by Dr. Donaldson, was accepted with the recommendation that the paragraphs dealing with legislation be referred to the Committee on Public Health Legislation.

*Report of Poliomyelitis Planning Committee
(distributed)*

Chairman Klump called attention to point No. 3 (page 8) and the statement on page 10: "The minimum requirements will be established by a committee of the State Medical Society" (lines 4-5).

The portions of this report referred to as pages 8 and 10 were approved and the remainder of the report accepted.

*Report of Commission on Physical Medicine
and Rehabilitation*

CHAIRMAN MARTUCCI: The 1949 House of Delegates passed a resolution (see pages 1696-7, December, 1949 PENNSYLVANIA MEDICAL JOURNAL) empowering the Commission on Physical Medicine and Rehabilitation to make a survey. The progress made is shown in Appendix D. We have received correspondence from numerous organizations. One letter is from the American Public Health Association, of which Roscoe Kandle, M.D., is director. (Read and distributed letter dated Feb. 20, 1950, from Dr. Kandle.)

In Philadelphia a similar committee has gone ahead with the survey and prepared questionnaires, with the assistance of the Health and Welfare Council, with no cost to the society except for its own commission's work. (Displayed questionnaire.) These forms are ready to be distributed. The work is quite burdensome and we must have some extra assistance. (Read resolution passed by the 1949 House of Delegates.)

If the Society wishes to go to the expense of hiring

special survey experts, the cost would approach \$20,000. It would be much less if they want to empower the commission and give the survey practical value through our own knowledge and contacts, plus the assistance of our Harrisburg office and with additional secretarial help.

DR. APPEL: The House of Delegates doubtless didn't realize that such expenditures would be involved. Would it not be wise to seek an opinion from the 1950 House of Delegates?

MR. PERRY: A relationship might be developed between this proposed survey and the new Brookings Institute survey, whose outline mentions "outpatient services for crippled children and adults," etc. If the Brookings Institute is going to do this job on a state-by-state basis, they may obtain the desired information.

On motion the budget of the Commission on Physical Medicine and Rehabilitation was increased by \$200.

On further motion Chairman Martucci's report was received and his commission instructed to continue the investigation of this problem and report to the 1950 House of Delegates.

On motion the budget for the Secretaries and Editors Conference was increased by \$750.

On motion the budget of the Commission on Preventive Medicine and Public Health was increased by \$200.

Miscellaneous

Chairman Klump announced that Mr. Arthur Dewees, executive secretary of the Pennsylvania Tuberculosis Society, had advised him that the cost of the digest of the digest of the "Keystones" survey would be nearer to 3½ cents than 5 cents per copy. (Secretary Donaldson has informed Mr. Dewees that the State Society may need 15,000 copies of the digest of the digest.)

Dr. Gagon expressed to Dr. George F. Lull, Secretary of the American Medical Association, the Board's appreciation of his presence during its meetings and at the Secretaries-Editors Conference as follows:

"Dr. Lull, you have, by your presence, added a very great deal to our Board meetings and by being on the firing line during the Secretaries-Editors Conference and intelligently answering many questions. You have graced our society by your presence and we express sincere appreciation for your time and the inspiration you have brought to us."

Election of Associate Members

Secretary Donaldson presented the names of 109 candidates for associate membership, all duly nominated by their respective county societies, as follows: Allegheny, 15; Berks, 5; Bradford, 1; Bucks, 2; Cambria, 3; Centre, 1; Chester, 1; Clarion, 2; Clearfield, 2; Clinton, 2; Dauphin, 2; Delaware, 2; Erie, 9; Lackawanna, 1; Lancaster, 7; Lawrence, 3; Lehigh, 5; Luzerne, 2; McKean, 1; Mercer, 10; Montour, 1; Northampton, 3; Philadelphia, 22; Schuylkill, 1; Venango, 1; Washington, 4; Westmoreland, 1.

On motion the candidates nominated for associate membership were declared elected.

SECRETARY DONALDSON: More than one member of the Bradford County Medical Society practices medicine in Sayre, Pa., but from necessity lives across the state

line in New York. The society is remodeling its by-laws and the secretary suggests that they state that active members of the Bradford County Medical Society should have the major portion of their practice in Bradford County.

DR. LULL: According to the Constitution and By-laws of the American Medical Association, a doctor shall belong to the county medical society in which his practice is located.

SECRETARY DONALDSON: Last night you heard Dr. Lull discuss the situation in which many hospital residents rate themselves as unable to pay the dues of the AMA. Our House of Delegates has made no provision for excusing anyone from the payment of dues except as an associate member. Dr. Lull has said that the AMA will excuse residents from paying AMA dues provided they don't have to pay county or state society dues. I need authority to continue stating that The Medical Society of the State of Pennsylvania makes no provision for excusing any hospital resident who accepts county society and state society membership from paying his dues.

DR. LULL: Something might be done by the AMA House of Delegates in June to modify this.

It was agreed to make no change and to await action of the American Medical Association regarding this matter.

Date of Next Meeting

Since no meeting rooms will be available at the Penn-Harris Hotel for meetings on May 25 and 26, 1950, which would concur with the meeting date of the Medical Service Association, it was agreed that the dates of the next Board meetings be May 11 and 12, 1950, in the Penn-Harris Hotel.

On motion the meeting was adjourned at 3:40 p.m.

GEORGE S. KLUMP, M.D., *Chairman*,

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*.

CHANGES IN MEMBERSHIP

New (62) and Reinstated (5) Members

ALLEGHENY COUNTY: Howard A. Bolton, George E. Cramer, Leslie A. Falk, John R. Friday, Asher Hollander, Joseph N. Jenkins, Jr., Edward J. Lauth, Jr., Lloyd D. Mayer, James P. Moore, and William R. Stinger, Pittsburgh; George R. Shore, Wexford.

BERKS COUNTY: Sergius V. Algin, Hamburg; Raymond R. Comess and Robert C. Frantz, Reading.

BLAIR COUNTY: Ralph S. Metheny, Altoona (affiliate member).

BUCKS COUNTY: Wilbert Lyons and Arthur A. Sweetser, Sellersville.

CAMBRIA COUNTY: (Reinstated) Frank G. Scharmann, Johnstown.

CENTRE COUNTY: (Reinstated) Ernest H. Coleman, State College.

CHESTER COUNTY: Norman E. Titus, Downingtown; William D. Schrack, Sr., Phoenixville.

CLINTON COUNTY: Joseph L. Witkowski, Avis.

DAUPHIN COUNTY: Michael J. Costick, Middletown.

DELAWARE COUNTY: Enio W. Tobia, Collingdale.

ELK COUNTY: Paul G. Cayaves, St. Marys; William W. Thompson, Johnsonburg.

FAYETTE COUNTY: Paul A. Mori, Jr., Brownsville.

LACKAWANNA COUNTY: Joseph A. Petriello, Dunmore; Ernest G. Shander, Peckville; Michael G. Yevitz, Scranton.

LEBANON COUNTY: John R. Wise, Rexmont; Paul Wm. Yocum, Lebanon.

LEHIGH COUNTY: Charles W. Schiffert, Fordwick, Va.

LUZERNE COUNTY: Sheldon G. Cohen, Pittston; Helen C. Cooper, Joseph A. Loftus, and William E. Peterson, Wilkes-Barre. (Reinstated) Achilles A. Berretini, Plains; John A. Hugo, Nanticoke; Joseph S. Kristoff, Hazleton.

LYCOMING COUNTY: Wendell H. Yealy, Williamsport.

MONTGOMERY COUNTY: Isabelle R. Schaffner, Amble; Lionel B. Shaffer, Roslyn; Samuel Younger, Norristown.

PHILADELPHIA COUNTY: Howard W. Baker, Daniel H. Barol, Irvin Cutler, Thomas G. Dickinson, Horatio T. Enterline, Marvin S. Greenberg, James M. Grist, William A. Haeberle, Francis G. Harrison, Jr., Louis F. La Noce, Joseph H. Marcy, Jeffery P. Moore, Charles H. Sillars, Vasilios A. Vlachos, and William A. Weaver, Jr., Philadelphia; Herman J. Bearzy and Paul S. Hoover, Lansdowne; Adolph W. Vogel, Narberth; Leroy D. Vandam, Springfield.

SCHUYLKILL COUNTY: Anton M. Miller, Pottsville.

SOMERSET COUNTY: Harold S. Hay, Somerset.

WARREN COUNTY: John W. Southworth, Warren (affiliate member).

WYOMING COUNTY: Theodore E. Patrick, Springville.

Transfers (26), Resignations (34), Deaths (18)

ALLEGHENY: *Transfers*—Israel Glick, Pittsburgh, from Philadelphia County Society; Edwin K. Vey, Pittsburgh, from Westmoreland County Society. *Resignations*—Abraham M. Balter, John W. Brown, Jr., Howard W. Kunkel, Harry M. Little, and Luvia S. Taylor, Pittsburgh; Benjamin E. Bryer, New York City; George Evashwick, Library; John E. Gordon, Lebanon.

BERKS: *Death*—Abner H. Bauscher, Reading (Jeff. Med. Coll. '08), aged 68; February 24.

BLAIR: *Resignation*—Giovanna D. Fusco, Hamburg.

BRADFORD: *Transfer*—Lenox Dick, Portland, Ore., to Multnomah County Medical Society. *Resignation*—Peter P. Mayock, Philadelphia.

CAMBRIA: *Resignation*—William M. Conway, Johnstown.

CENTRE: *Transfers*—Charles J. Cullen, State College, from McKean County Medical Society; James

M. Campbell, Jr., State College, from Lycoming County Society.

CHESTER: *Transfer*—Robert N. Byrne, Bryn Mawr, from Philadelphia County Society.

COLUMBIA: *Death*—Charles S. Sentner, Benton (Jeff. Med. Coll. '29), March 3, aged 44.

DAUPHIN: *Transfer*—Amita W. Harper, Washington, D. C., to District of Columbia Medical Society. *Death*—J. Loomis Christian, Sr., Harrisburg (Coll. Phys. & Surg., Balt. '90), February 27, aged 84.

DELAWARE: *Transfer*—Robert L. Hall, Havertown, from Philadelphia County Society.

ERIE: *Resignations*—August H. Becker, Cleveland, Ohio; Phil C. Engelskirger, Indio, Calif.

FAYETTE: *Death*—William H. Mease, Uniontown (Univ. Pgh. '37), March 12, aged 36.

LACKAWANNA: *Resignation*—J. Donald Casey, Jermyrn. *Deaths*—Andrew W. O'Malley, Clarks Summit (Ill. Med. Coll. '08), March 11, aged 67; Stephen S. Watson, Moosic (Jeff. Med. Coll. '94), February 25, aged 82.

LANCASTER: *Death*—John M. Wenger, Terre Hill (Univ. Pa. '10), February 25, aged 67.

LAWRENCE: *Transfers*—John F. Brzoza, New Castle, from Philadelphia County Society; David B. Connery, Tyler, Texas, to Smith County (Texas) Medical Society. *Death*—Howard C. Harper, New Castle (Jeff. Med. Coll. '03), March 6, aged 75.

LUZERNE: *Deaths*—Peter E. Fagan, Hazleton (Jeff. Med. Coll. '09), February 17, aged 66; Peter H. Jamison, Nescopeck (Med.-Chi. Coll. '98), March 1949, aged 74.

LYCOMING: *Resignation*—Thomas C. Brandon, Anchorage, Alaska. *Death*—James H. Burrows, Williamsport (Univ. Pa. '20), March 6, aged 53.

MERCER: *Death*—Harvey E. Massy, Sharon (Ohio State Univ. '11), March 11, aged 64.

MONROE: *Transfers*—Malachi W. Sloan, Dayton, Ohio, to Montgomery County (Ohio) Medical Society; Charles H. Rushmore, E. Stroudsburg, from Lackawanna County Society. *Death*—Walter L. Angle, E. Stroudsburg (Maryland Med. Coll. '03), June, 1949, aged 71.

MONTGOMERY: *Transfers*—C. Wilmer Brobyn, Minneapolis, Minn., to Hennepin County (Minn.) Medical Society; Michael S. Dudich, Elkins Park, from Philadelphia County Society; Harold S. Tuft, Norristown, from Philadelphia County Society.

NORTHAMPTON: *Transfer*—Maurice R. Schmoyer, Bethlehem, from Berks County Society.

PHILADELPHIA: *Transfers*—Earl W. Clawater, Jr., Tyler, Texas, to Smith County (Tex.) Medical Society; Ilka Deutsch-Dickman, Alexandria, Va., to District of Columbia Medical Society; Herbert S. Gaskill, Indianapolis, Ind., to Marion County (Ind.) Medical Society; J. Vernon Knight, New York City, to New York County Medical Society; Clarence C. Livingood, Galveston, Tex., to Galveston County (Tex.)

Medical Society; Arthur R. Payzant, New Orleans, La., to Orleans Parish Medical Society; John De Carlo, Jr., Baltimore, Md., to Baltimore County (Md.) Medical Society; Evan B. Hume, Philadelphia, to Cameron-Willacy County (Tex.) Medical Society; Ellis K. Hultzman, Camden, N. J., to Camden County (N. J.) Medical Society; Axel Olsen, Philadelphia, from Bradford County Medical Society. *Resignations*—Alexander B. Arthur, Marie Curry-Frey, Ruth F. Harral, Edward Neill Wood, Joseph S. Burkle, Arthur M. McGinniss, Howard Myers, Phyllis D. Schaefer, Samuel Schwartzman, Elmer L. Straub, Lawrence Hall, Thomas V. Finch, David Jan Cohen, and Alfred Trosow, Philadelphia; Samuel Holmstock, Atlanta, Ga.; Emanuel J. Levin, Cincinnati, Ohio; Oscar E. Heim, Ft. Monmouth, N. J.; Alice R. Erb, Rochester, Minn.; Sara A. Mercer, New Orleans, La. *Deaths*—Eldridge L. Eliason, Philadelphia (Univ. Pa. '05), March 6, aged 70; Stephen Mitterling, Philadelphia (Med.-Chi. Coll. '11), March 19, aged 71; David Nathan, Philadelphia (McGill Univ. '06), February 26, aged 72.

SCHUYLKILL: *Transfer*—Joseph T. Marconis, Pottsville, from Philadelphia County Society. *Death*—Christian Grubler, Shenandoah (Med.-Chi. Coll. '99), February 27, aged 80.

SOMERSET: *Resignation*—William W. Keim, Davidsville. *Transfer*—Wilbur W. Westfall, Oakland, Calif., to Alameda County (Calif.) Medical Society.

WARREN: *Transfers*—Homer H. Lewis, Jr., Warren, from Clearfield County Society; Robert D. Donaldson, Warren, from McKean County Society.

WESTMORELAND: *Resignation*—Joe Funderburgh, Torrance.

WYOMING: *Transfer*—Walter J. Blasco, Wyalusing, from Luzerne County Society. *Death*—Van C. Decker, Nicholson (Jeff. Med. Coll. '96), February 4, aged 81.

YORK: *Resignation*—Colin H. Hartley, Riderwood, Md.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since March 14. Figures in first column denote county society numbers; second column, State Society numbers.

Mar. 14 Westmoreland 120.

	149-185	8303-8340	\$874.00
Lawrence	57-68,		
	70-76	8341-8359	437.00
Somerset	22	8360	23.00
Washington	126-128	8361-8363	69.00
Clearfield	44	8364	23.00
Fayette	92-95	8365-8368	92.00
Mercer	64, 70-79	8369-8379	253.00
Jefferson	45-48	8380-8383	92.00
McKean	38-41	8384-8387	92.00
15 Lackawanna	214-220	8388-8394	161.00
Mifflin	24-30	8395-8401	161.00

Mar. 15	Bedford	7-8	8402-8403	\$46.00
	Erie	194-199	8404-8409	138.00
16	York	137-143,		
		155-157	8410-8419	230.00
	Lycoming	114-124	8420-8430	253.00
	Lackawanna	221-227	8431-8437	161.00
	Chester	106-108	8438-8440	69.00
	Cambria	143	8441	23.00
17	Franklin	76	8442	23.00
	Warren	47	8443	23.00
20	Lancaster	215-217	8444-8446	69.00
	Delaware	248-250,		
		255-262	8447-8457	253.00
	Venango	42-43	8458-8459	46.00
	Berks	229-236	8460-8467	184.00
	Somerset	23-24	8468-8469	46.00
	Butler	53-58	8470-8475	138.00
	Fayette	96-99	8476-8479	92.00
	York	158	8480	23.00
	McKean	42-46	8481-8485	115.00
21	Carbon	36	8486	23.00
	Columbia	42-44	8487-8489	69.00
	Northampton	184	8490	23.00
	Clinton	23	8491	23.00
	Chester	109	8492	23.00
22	Lehigh	170-209	8493-8532	920.00
	Lawrence	77-78	8533-8534	46.00
	Montgomery	262-281	8535-8554	460.00
	Beaver	99-124	8555-8580	598.00
	Bucks	75-77	8581-8583	69.00
	Armstrong	39-40	8584-8585	46.00
23	Luzerne	311-330	8586-8605	460.00
	York	159	8606	23.00
	Lackawanna	228-231	8607-8610	92.00
	Northampton	182, 233	8611-8612	46.00
	Blair	78-80, 82-100	8613-8634	506.00
	Centre	22-34	8635-8647	299.00
	Butler	59-60	8648-8649	46.00
	Cambria	144-145	8650-8651	46.00
	Schuylkill	106-123,		
		125-132,		
		140-143	8652-8681	690.00
25	Northumberland	67-68	8682-8683	46.00
	York	163	8684	23.00
	Somerset	25-26	8685-8686	46.00
	Tioga	23	8687	23.00
27	York	160-162	8688-8690	69.00
	Berks	237-239	8691-8693	69.00
	Chester	110-111	8694-8695	46.00
	Lebanon	69-70	8696-8697	46.00
	Delaware	263-268	8698-8703	138.00
	Washington	129	8704	23.00
28	Blair	81, 101, 103-104	8705-8708	92.00
	Blair	102	8709	11.50
	Crawford	47-49	8710-8712	69.00
	Lawrence	79-80	8713-8714	46.00
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	Clinton	24-25	8717-8718	46.00
	Warren	48	8719	11.50
29	Clearfield	45	8720	23.00
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	York	164	8723	23.00
	Luzerne	331-338	8724-8731	184.00
	Cambria	146	8732	23.00

Mar. 30	Indiana	39-40	8733-8734	\$46.00
	Greene	18-22	8735-8739	115.00
	Blair	105-107	8740-8742	69.00
31	Carbon	37	8743	23.00
	Bradford	41-44	8744-8747	92.00
	Philadelphia	2107-2607	8748-9248	11,523.00
	Northampton	234	9249	23.00
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Do you have any puzzling diagnostic problems to solve or a paper to prepare for professional or lay audiences? If so, why not take advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? At the present time there are more than 103,000 reprints and tear sheets from various publications filed in the library for your use.

There has been a continuous increase in the usage of this service, which proves that it has served our physicians well.

The following requests were filled during the month of March:

Progress of medicine (2)	Desoxycorticosterone
Anorexia nervosa	Undulant fever
Surgery of the esophagus	Trichinosis
Dermatomyositis	Skin tests
Childbirth without fear	Intra-oral carcinoma
Carcinoma of the stomach	Practical nursing
Loeffler's syndrome	Teeth, hair, and eyes
Compound E	Treatment of dysmenorrhea
Skin diseases	Pulmonary infarction
White bile	Opacity of the eyes
Female sterility	Technique of gonioscopy
History of medicine	Cord bladder
Pneumoconiosis	Paget's disease
Penicillin	Leukemia
Streptomycin (2)	Experimental cancer
Mesenteric lymphadenitis	Sex deviate
Q fever	Inversion of the uterus
Pulmonary sarcoidosis	Allergies
Radioactivity	Dermatology
Drugs	Neurology
Cancer	Skin rash in children
Albright's syndrome	Heart diseases
Lymphoid tumors	Nutritional disorders
Status asthmaticus	Toxicity of streptomycin
Polioomyelitis	Penicillin sensitivity
Electroencephalography	Lateral sinus thrombosis
Socialized medicine (2)	Animal experimentation

Hypersplenism	Warfare	Pulmonary manifestations of brucellosis
Epilepsy	Sulfonamides	National health service in Great Britain
Gallbladder function	Silicosis	Postoperative care of the aged surgical patient
Occupations for women	Effects of sulfanilamide	Anesthesia in ophthalmic surgery
Office planning	Lipoid nephrosis	Typhoid fever mortality during Spanish-American war
Premenstrual tension	Physicians	Diethylstilbestrol in treating pregnancy complications
Carcinoma of the bladder	Laboratory techniques	Workmen's compensation and insurance
Alcoholism	Noise	Treatment of chronic bronchial asthma
Papilloma of the larynx		Vitamin C therapy in arthritis
Solitary cecal diverticulitis		Cholesterol in cardiovascular disease
Syphilis of the central nervous system		Registered physicians in Pennsylvania
Intravenous procaine therapy		Radium treatment of uterine carcinoma
Ventricular hypertrophy and pneumoconiosis		Convalescent homes and hospitals licensed in Pennsylvania
Treatment of syphilis vulgaris		BCG vaccine in the prevention of tuberculosis
Pregnancy complicating diabetes		Therapy of diseases of the ear, nose and throat
Cardiac patient as a surgical risk		Aminopterin in treatment of leukemia
Blood cholesterol determination		Treatment of rheumatic fever
Functional uterine bleeding		Cardiac conditions associated with pneumonectomy
Health aspects of air pollution		Etiology and pathogenesis of diabetes
Physical medicine in rheumatoid arthritis		Preparation for a medical career
Pulmonary edema and embolism		Appendicitis mortality in Pennsylvania
Hodgkin's disease of the lung		

GREETINGS FROM THE DEPARTMENT OF INTERNAL REVENUE

Several months ago a small article appeared in one of the "trade journals" telling the story of one physician who wagered that if his colleague would write a letter to the President denouncing socialized medicine, he too would be invited by the Department of Internal Revenue to explain the figures on his form 1040 for the year of 1946. The experiment was conducted and the results were as predicted. This may be construed to imply political persecution of the medical profession. It may, however, have been pure coincidence.

Of this you can be sure—if you haven't already had an interview with a deputy collector, you will have some time during the year 1950! Those of you who have been through this procedure may have had your return of 1946 rechecked. After March 15 the returns of 1947 become the target. So be prepared and start gathering and sorting all the canceled checks, the monthly bank statements (your bank will have photostats of these made for a nominal fee if you, like I, destroyed them after you checked the balance with the figures in the check book), records of bond sales, and all other financial records that have to do with 1947. In the coming battle of wits you will need all the supporting evidence you can muster.

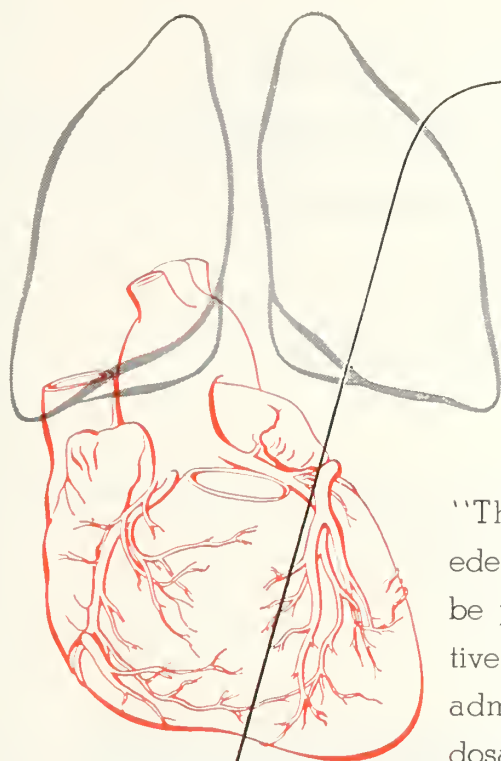
Although these deputy collectors do not get a percentage bonus on funds recovered, there is no denial that for a given number of tax returns assigned to a collector for investigation, he is expected to recover a predetermined amount. The collectors are rated with salaries commensurate with their ratings. Therefore, an eager beaver who consistently reaches or exceeds his

quota of recovered funds is in line for a better rating and a bigger salary. Realizing this, we can't be too critical of their methods and tactics for, if the positions were reversed, we would do the same.

Because of a mathematical deficiency and an inability to comprehend the terminology of forms 1040 and 1040-ES with all the do's, don'ts, checks, deducts, adds, estimates, etc., we have left this bit of governmental annoyance in the hands of an expert. We have always been strongly opposed to self-diagnosis and self-medication on the part of the lay public, for all too frequently they are wrong on both counts and end in difficulty with needless pain and suffering. Is this same principle not true when a physician without training acts as his own accountant? And did you know that certain accountants are registered or enrolled in the U. S. Treasury Department and are thereby qualified to represent their clients in any D. I. R. controversy, and the client does not have to make a personal appearance?

Well, when we first got the notice, the first reaction was similar to the time the Sunday School teacher caught us whispering too loudly a few words of profanity—that sheepish feeling of guilty innocence! We immediately called our C. P. A., and he was unperturbed and most reassuring. "Just get your things together and bring them to my office—I'll handle the rest. I'll let you know if we get into difficulty." So far he hasn't called us and we are just a bit hesitant to call him!

Again we ask—could this investigation campaign of the medical and dental professions be considered as persecution by a governmental agency whose proposed activity in the field of health we strongly oppose?—*Bulletin of Lancaster City and County Medical Society.*



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1. Barach, A. L.: Edema of the Lungs, *Am. Pract.* 3:27 (Sept.) 1948.

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 2. Description or nature of exhibit (attach 200-word description to this blank together with a rough sketch of the exhibit).
 3. How much floor space will you require?
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 5. How much side wall space will you require?
 6. Will you require shelf space? If so, how much?
 7. Other material or equipment required.
 8. Name of exhibitor.
..... (Street) (City)
 9. Name of institution cooperating in exhibit (if desired).
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The average sized booth will have a back wall of ten feet and two side walls of eight feet each. However, additional back wall space is available if needed.

The Medical Society of the State of Pennsylvania will provide without cost to the exhibitor the following: exhibit space, solid paneled booth which permits tacking of material, shelves, booth sign, electrical outlets, and straight chairs. All other costs are to be borne by the exhibitor including any view boxes needed.

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*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, 1937, Vol. XLVII, No. 1, 58-60

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

HISTORICALLY, tuberculosis has been a predominantly urban disease in the United States. Associated with poverty, congested housing, poor nutrition, and overexertion, tuberculosis has taken its greatest tolls in the slums of the big city. The decline in the tuberculosis death rate since 1900 has been due in the main to urban developments, among which are improvement in living standards and the isolation and treatment of cases in hospitals. In the meantime, what has been happening to tuberculosis in rural areas?

TUBERCULOSIS AND ITS CONTROL IN RURAL AREAS

Exact figures on tuberculosis in rural areas are not available. The recording of deaths in the United States before 1937 was by place of occurrence, not by place of residence. As hospitalization of the tuberculous in sanatoriums, usually located in country districts, increased, more deaths were artificially credited to rural places. Census Bureau definitions of "rural," moreover, have been changed as has the accuracy of death reporting in country districts. Despite these limitations, certain general trends in the tuberculosis death rate, as between cities and rural districts, are evident.

Rural and Urban Tuberculosis Death Rates

While tuberculosis mortality has been declining in urban and rural sections alike, it is probable that the rate of decline in the cities has been greater than in the country. In 1890, when hospital deaths were too few to influence the rural-urban comparisons substantially, the death rate for pulmonary tuberculosis in the cities of registration states was 62 per cent higher than the rate in the rural parts of these states. The differential fell to a total urban rate (49.4 per 100,000) only about 20 per cent higher than the rural rate (41.3 per 100,000) in 1940.

Accurate urban and rural tuberculosis death rates cannot be determined for any years since 1940. It is estimated, however, that the approximate urban tuberculosis death rate in 1946 was 38.7 per 100,000 and the rural rate 34.9. These

figures represent a further decline of the urban rate at a more rapid pace than that of the rural rate.

Even in 1940 the rural tuberculosis death rate was higher than the urban in certain demographic groups. The rural death rate for white females is actually higher than the urban at all ages from 15 years up. Among non-white females, the rural death rate exceeded the urban at ages above 54 years. Among males the rural death rate exceeded the urban in the highest age groups.

These findings illustrate what happens to the tuberculosis death rate in sex-age groups least subject to frequent epidemiologic contacts. Of the various groups, white women have the least contact with the general population. Among aged persons, contact is also likely to be minimal. In other words, among groups with the fewest epidemiologic contacts, the rural death rate from tuberculosis is already higher than the urban. Case finding and isolation of active cases from a community reduce epidemiologic contacts. As these steps are taken in the cities, we may expect the curves for urban and rural tuberculosis death rates ultimately to cross, with urban rates becoming lower than rural for all age-sex-racial groups.

Rural Life and Tuberculosis

Controlling tuberculosis in rural America is made difficult by the same factors that impede

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Extensive studies* by the Bureau of Human Nutrition have established that breakfasts rich in protein and supplying 500 to 700 calories, effectively promote a sense of well-being, ward off fatigue, and sustain blood sugar levels at normal values for the entire morning postbreakfast period.

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The subjects on the higher protein breakfasts "reported a prolonged sense of well-being and satisfaction." The findings indicated that the beneficial effects of the high protein breakfast on the blood sugar level may extend into the afternoon.

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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



American Meat Institute
Main Office, Chicago...Members Throughout the United States

the provision of general public health and medical services. Low per capita income and low population density, with concomitant deficiencies of medical personnel, facilities, and health agencies, create handicaps in the battle against tuberculosis as against most diseases.

The central fact that characterizes the approximately 55,000,000 Americans living in rural areas, as compared with city-dwellers, is lower average family incomes. Citation of only the most obvious of the elements entering into a standard of living—education, housing, nutrition, and the use of labor-saving devices—reveals the basic distinction at rural and urban levels. Rural educational levels, including education in personal hygiene and living habits, are woefully below the urban. It may not be so widely recognized, but the Census Bureau figures show that average rural housing is actually more congested than urban. Rural families are larger than urban and acres of land around a home do not add space to the rooms in which the family eats, sleeps, and lives.

The relevance of this to the problem of tuberculosis would seem to be this: if tuberculosis is the classical "social disease," the socio-environmental factors contributing to its occurrence are, with one important exception, epidemiologic contacts, found most strikingly today in rural parts of the United States. Except for the increased opportunity for the person-to-person spread of tubercle bacilli in the cities, the conditions of rural life in America today provide the basis for a higher tuberculosis mortality than do those of urban life.

Measures for Urban and Rural Tuberculosis Control

The measures for reducing epidemiologic contact with unrecognized cases of tuberculosis which are being employed in urban areas are case finding through private physicians, public health tuberculosis clinics, and mass x-ray sur-

veys, and isolation of cases through hospitalization. There are special handicaps to all these measures in rural America. Yet if rural tuberculosis is to be reduced, comparable measures of control are necessary.

The Rural Challenge

As living conditions improve, and effective case finding, treatment, and isolation of patients reduce the prevalence of tuberculosis in the cities, the task of final eradication of the disease in the rural areas must be faced. Present trends point to the time when tuberculosis may become the predominantly rural problem that typhoid fever, once an urban scourge, has become today.

The lesser epidemiologic contacts of country-dwellers is a distinct advantage in fighting the disease. While it may be harder to find cases among rural people and harder to get them isolated and treated, the channels of person-to-person spread are fewer.

The attack on rural tuberculosis cannot be effective unless it is launched on all fronts of rural health service. Rural housing, education, nutrition, and general living standards must be elevated. The services of competent physicians must be available for the everyday care and prevention of illness, and hospital services must be expanded as needed. Public health agencies must be extended and x-ray services for periodic chest checkups must be made accessible. Social measures for the families of persons disabled with tuberculosis must be provided.

Unless these steps are taken, we may expect a permanent reservoir of tuberculosis to smolder indefinitely in rural districts. With these steps taken in city and country alike, tuberculosis can be eradicated from America.

Tuberculosis and Its Control in Rural Areas.
Milton I. Roemer, M.D., M.P.H., *Public Health Reports*, October 7, 1949.



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*Pitt, C.K.: *The Art and Science of Artificial Infant Feeding*, J.M. Asso. Ala. 19:101 (Oct.) 1949.

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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street, Indiana

PRESIDENT'S MESSAGE



Long after we have finished our formal schooling through the grades, preparatory schools, and colleges, we very often wish that we might again experience the joys of those days long past. We forget that our education goes on and on, for the University of Life

has arranged courses for all of us, no matter what our chosen paths may have been.

It has been so truly said that the work of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania offers to each and every member one of the finest of these courses. It can be yours for the asking simply by offering yourself in service to the auxiliary in your own county. The tuition is free; the classes are of your choosing; tests are given only for friendliness and willingness to devote a little time and effort for a good cause; and all grades are E's—not for Excellence but rather for Effort and Experience.

The months of May and June will find county auxiliaries installing new officers and new presidents appointing committee chairmen, thus marking another milestone in auxiliary history. A new group of physicians' wives will be enrolled in the great university for a year of thrilling experiences.

How many of you will be among these chairmen or officers? How many will have been too timid to accept a place because of fear of failure or of possible mistakes? All too many, I am sure, for each year we hear of the difficulties that counties have in filling the posts essential to carry on the work.

In the auxiliary there is no such thing as failure. As for mistakes—of course you may make them, we all do—they are the best proof we have that an effort has been made to complete an assignment somewhere along the line. Too often we mistakenly think of failure as an end to everything. I believe we should look upon failure as a

challenge for the future and a better reason for again trying to reach the goal.

There is no traditional approach to a given task in any organization, and this is particularly true in our auxiliary. Each year those in charge, in county and state alike, approach their tasks with high aims and many dreams of progress, only to find that it is not humanly possible to accomplish all that one may have set out to do. For example, we would like to have achieved a goal of 6000 new members this year, but of course it was not possible. Nevertheless, the gain of almost 500 new members does not reflect failure. Rather it is reason for great rejoicing that we have climbed so far up the ladder.

Much of the seed sown in any one year may not bear fruit until several years later, but that is not failure. When that seed has been cultivated, tended, and nourished through several administrations, it will be strong enough to bring forth healthy fruit in abundant measure.

None can succeed who never try. By the same token none can fail, for there can be neither success nor failure unless *effort* has been expended. We experience disappointment perhaps when our plans seem to fail, but it is not true failure. In expending the *effort*, we have made ourselves grow and that is success in the class of Life's University. As we work toward a goal, we are exposed to failure which comes not from a lack of success but from a suspension of *effort* before reaching that goal.

TWENTY-SEVENTH ANNUAL MEETING WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Hotel Fairmont, San Francisco

June 26 to 30, 1950

A cordial invitation is extended to all members of the Auxiliary and guests attending the convention of the AMA to participate in the social functions and the general sessions of the Auxiliary.

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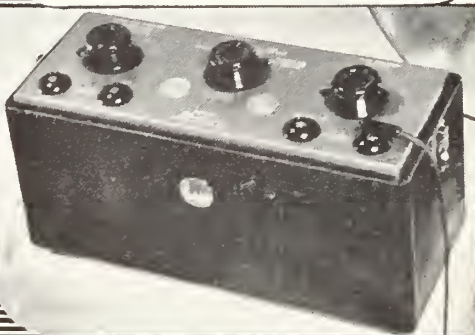
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Failure can be challenged by good planning, charting a course, and following through; it can be encouraged by faint heart, but *confidence* will overcome it every time. Of course, we can play it the safe way and avoid all failure and mistakes by never trying anything, but I doubt if many auxiliary members are willing to accept that type of safety or such a do-nothing existence.

You may never know what talent you possess, what capacity you have for influencing others, what strength for service you are capable of unless you try. When your president asks you to serve on a committee, remember that "I can't" never did anything but that there is untold magic in the phrase "I can try."

"I can't" sits still, spineless and disheartened; "I can try" squares his shoulders and takes the first step forward in getting his job done. It will work every time. TRY IT. Enroll now in the best school you will ever know—the University of Life.

(MRS. DRURY) ELIZABETH M. HINTON,
President.

1950 CONFERENCE MINUTES

The fourth annual conference of county presidents, county presidents-elect, and executive board members was held in Harrisburg, March 9 and 10, 1950. One hundred and thirty-two were enrolled in the training class, which is the conference, and forty-two counties were represented.

A dinner preceded the opening of the conference on Friday evening, March 9. It was a pleasant get-together of enthusiastic auxiliary members. Mrs. Drury Hinton, president of the Auxiliary, presided and George S. Klump, M.D., of Williamsport, was the dinner speaker. He gave the results of a public health survey in Pennsylvania made during the past three years and expanded on two of the findings: the need of a merit system in the Department of Health in Pennsylvania, and the need for local health units with trained personnel. He explained that the entire success of the survey is in the hands of enlightened leaders at the local level and he asked for the Auxiliary's help in promoting this community understanding of how health needs suffer under the political appointee system and what to do about it.

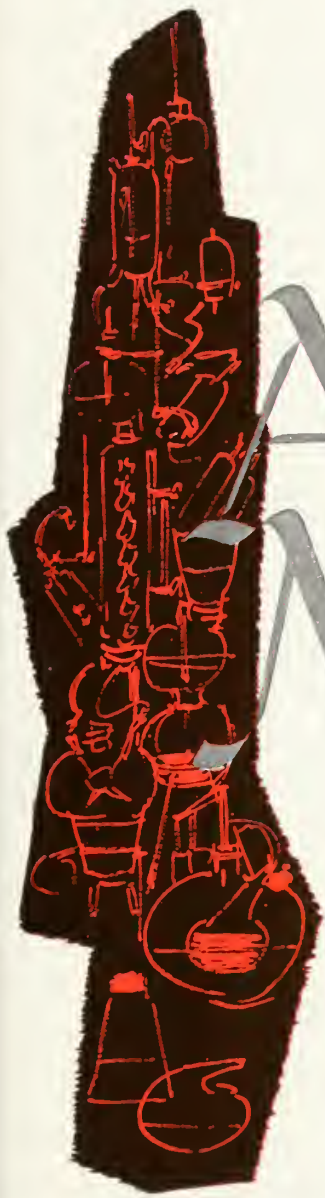
Mrs. Howard H. Hamman, president-elect of the Auxiliary, opened the conference program following a greeting from Howard K. Petry, M.D., chairman of the Advisory Committee to the Auxiliary. The Auxiliary secretary, Mrs. Frank P. Dwyer, was elected to serve as secretary for the sessions. Each guest at the dinner had an attractive copy of the agenda before her and a vote of the group endorsed the program as it was printed.

Francis F. Borzell, M.D., speaker of the House of Delegates of the American Medical Association, gave

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Bottles of 16, 250 mg. each capsule.

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details of the Association's National Education Campaign. It was interesting to hear of the inner workings and the hopes of the committee in charge and of the extensive program set up to tell the public the perils of the welfare state planned for America. He urged help from the Auxiliary, at the grass roots level, warning that any program on the national level will fail unless the people in the towns and villages understand the perils facing them.

Mrs. Albert F. Doyle asked for questions from the audience so that Dr. Borzell might make points clear. The members asked the speaker what auxiliaries might do about the Hoover Commission, about the Flanders-Ives Bill, and how they might refute *Time's* untrue attack on organized medicine in a recent issue. Dr. Borzell answered these and other queries and again asked for a deepening and broadening of auxiliary efforts in the health education program at community levels.

The theme for the next part of the conference was "Crossroads of the Road Ahead" and the chairmen of the committees on publicity, medical benevolence, program, and *Today's Health* explained details of the year's plans in each group. Suggestions for county auxiliary work were well received and questions were answered. The chairmen consider the "crossroads" named, well paved, and in full use. Discussions were led by Mrs.

Daniel H. Bee, chairman of publicity, Mrs. Stephen S. Dodd, chairman of medical benevolence, Mrs. Otto C. Reiche, chairman of *Today's Health*, and Mrs. Frank H. McNutt, Jr., chairman of program.

The "power for the road ahead" is procured by an active membership, and as complete a membership as possible. To this end the three vice-presidents of the Auxiliary—Mrs. J. Frederic Dreyer for the eastern section, Mrs. James L. Whitehill for the western section, and Mrs. Archibald Laird for the central section—had led membership drives in these three sections of the State. Aided by councilors and county presidents, they gained 481 new members, and the conference was given the results in visual form by a poster, the details of which were explained by the vice-presidents. The eastern section of the State, led by Mrs. Dreyer, won the "blue ribbon award." There is one county, McKean, still unorganized in the State, in spite of intensive work by both Mrs. Hinton and Mrs. Hamman. McKean County will not be abandoned yet however. The goal for one hundred per cent county organization will be met somehow, everyone agrees.

Friday morning found the conference assembled again for discussions on other phases of the over-all program of auxiliary endeavors. "The highway to good public relations" was followed in discussion and question and

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answer form and the various "highway" materials and signposts were gone into with Mrs. Paul C. Craig presiding. Posters, voluntary insurance, personal contact plans, and successful projects in public relations were all outlined in detail and questions answered about procedure. Conference members were given valuable examples of public relations work applicable to small county groups and to city auxiliaries. They learned that one member in a community can pave the public relations highway very successfully in various ways.

Mrs. John V. Foster, Jr., explained poster work to the members present. This is a medical society project, being aided by auxiliaries. Last year 19 counties took part and this year 33 auxiliaries are working actively for their county medical societies. Mrs. Herman A. Fischer, Jr., told of how Luzerne County worked up interest by contacting teachers in institutes, giving radio talks on the subject, interesting mothers and art teachers, and offering local prizes. Mrs. Herbert C. McClelland, of Lebanon County, discussed poster plans in her county. Personal contacts with teachers were made by auxiliary members. Parties were arranged for the

winners, and the medical society entertained the county winners and their parents at dinner. The auxiliary workers were invited too. Doctors took the posters to their offices and hung them for a period of time. The judging took place in the medical society headquarters and the judges were all college art teachers. Each community had its own presentation of awards to local winners before the county prizes were awarded. It was a very personal campaign and worth a great deal in public relations value.

Mrs. Frederic B. Davies outlined the progress of Blue Shield response in the State. She urged members to learn the points involved in voluntary insurance plans and to explain them to their lay clubs. She asked members to get executives from the Blue Shield offices to talk to lay groups when such programs are planned. Above all, members were asked to join Blue Shield on a group or individual basis.

As an element of good public relations, Mrs. F. Allen Rutherford, of Lebanon, told of her county's project of first renting and then buying a hospital bed to lend to the needy. The bed was lent through the Visiting



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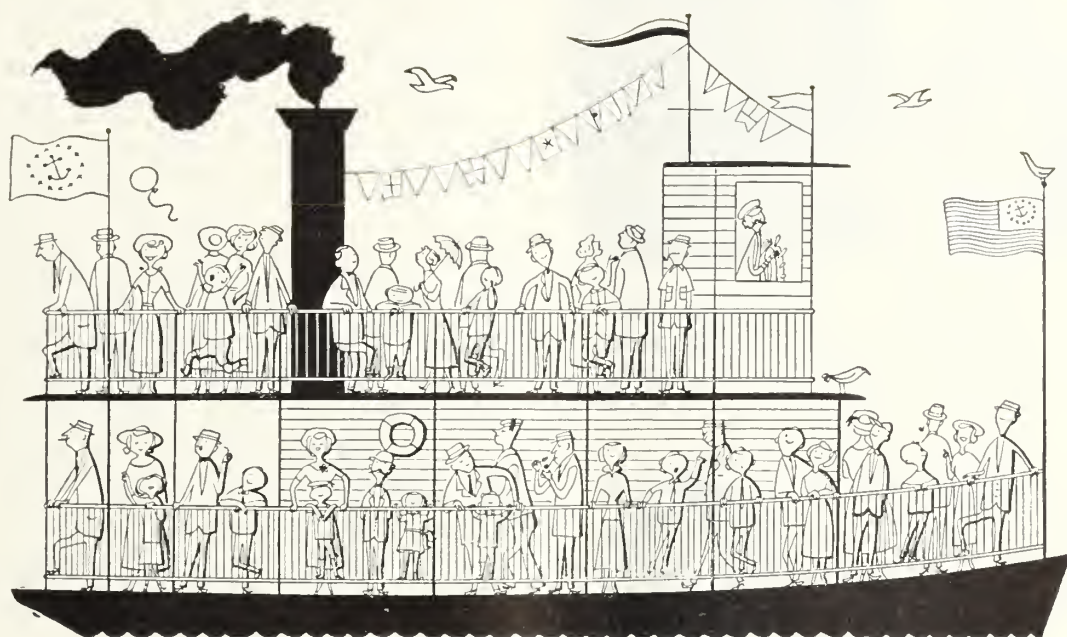
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Nurses Association. Plans for a second bed are being made. Another county reported lending wheel chairs on the same plan as a public relations venture.

Mrs. Maurice V. Ross, of Beaver County, proved that a county-wide personal contact program can be completed, and in a big way, if members and officers really work at it. She discussed the checks they made and the actual contacts that worked. One task for contact committees was to check on registrations for voting privileges in the May primaries and the November election.

The matter of lay club endorsements of voluntary insurance plans and resolutions against compulsory health insurance was thoroughly explained by Miss Suzanne Treadwell, staff assistant to the Committee on Public Relations of the State Medical Society. The need for such club action and the value of this club cooperation at community levels make for success in the state and national organizations when such action is asked of them. Pennsylvania clubs have responded nobly to the appeals of county auxiliaries in this respect.

Two guests, Mrs. W. E. Hoffman, third vice-president of the Woman's Auxiliary to the American Medical Association, and Mrs. Hugh Henry, president-elect of the New York Auxiliary, were introduced and spoke briefly, as did E. Roger Samuel, M.D., president of The Medical Society of the State of Pennsylvania.

The question of a possible bill before the State Legislature to legalize using pound dogs for animal experimentation in medical schools and research laboratories was discussed by J. Parsons Shaeffer, M.D., of Jefferson Medical College, Mr. Ralph Rohweder, of Chicago, and Mr. Leo E. Brown, executive assistant, Committee on Public Relations of the MSSP. Mr. Rohweder had just come from New York where the proponents of such a bill there are having a stormy time. Although only 1 per cent of the population are antivivisectionists and another possible 8 per cent lean that way, this 9 per cent are so voluble and work so hard for what they believe that the whole issue of medical research is endangered. The 92 per cent who know that no advance in medicine has been or can be made without animal experimentation are so sure of the value of the program that they cannot conceive of any successful opposition. This apathy is something that must be overcome.

Auxiliary members have been working on the pending bill and the one defeated in the last legislature and they know all the silly and definitely untrue statements that the minority can advance. The speakers urged the Auxiliary to start a campaign of deflating the false charges flying about. They were asked to tell the public that funds collected in polio and cancer drives are being wasted because of the lack of dogs for laboratory research, while in New York City alone 250,000 pound dogs a year are destroyed. Only one-half the 9000 dogs needed for New York medical schools and laboratories are now available. The same ratio exists in most medical centers. The public must know that pound dogs only are used, not family pets, and pound dogs only after the waiting period for release is up. Dogs are never tortured; they are anesthetized and treated kindly and most of them are actually pets in the centers where

they are faithful workers. They live under ideal conditions of housing and feeding, since research is an exact science. Ninety per cent of the experimental animals do not undergo surgery at all, but are used for nutritional tests, drug effects, and other scientific experiments. Dogs are used almost exclusively because they live in the nearest possible manner to that of the human. The speakers gave many examples of dogs' devotion to the cause they work for in laboratories. Auxiliary members will try to pass on to the lay public in home communities the suggestions given to them. It was quite a thrilling story, and the three speakers had close attention throughout the discussion.

A luncheon meeting closed the conference. Mrs. Paul C. Craig, AMA Auxiliary public relations chairman, discussed "The Power of a Woman," stressing the individual member's personal responsibility in the auxiliary program, a responsibility which not a single member can afford to neglect. Two women working on the National Education Campaign and the auxiliary's part in it, Miss Audri Ursin of Whitaker and Baxter and Mrs. Kris Peterson of the Public Relations Department, American Medical Association, were guests at the conference and addressed the luncheon meeting. Neither had had any contact with any auxiliary in action and both spoke of their appreciation of the part that Pennsylvania county auxiliaries are taking in advancing the American Medical Association's program.

Most of the members who attended the conference felt that they had gained much insight into the problems of the day and much help in carrying out their individual plans at the county level. All were agreed that two full days next year would not be too much time spent in planning for another year's work.

Aside from the valuable exchange of ideas and new approaches to old problems which the conference developed, the members were cheered as always by the renewal of personal experiences and the greetings and associations of new and old friends. Nowhere else can there be found banded together in a group so many women whose problems are the same, whose households are identical, whose time is never their own, and whose lives are faced with crises at any hour of the day or night. And not a single one of them would change a minute of it all. Each member returned home refreshed and impressed and happy that she is not alone in any single experience in her crowded life. All her auxiliary friends are right with her, busy and thrilled too.

(MRS. FRANK P.) MARY H. DWYER,
Recording Secretary.

A Twentieth Century Fund report estimates public debt per person in the United States as follows (including total debt of national, state and local governments):

1913	\$60
1922	300
1932	310
1945	1,970

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MEDICINE—Intensive General Course, Two Weeks, starting October 2. Electrocardiography and Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastro-enterology, Two Weeks, starting May 15. Liver and Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.

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There was no essential difference in the skin temperature during the carbon dioxide and plain water baths.

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in the mineral water bath. This increase did not occur in the plain water bath.

No evident variation in the oxygen consumption occurred with either bath.

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It is, therefore, concluded that the results obtained in the treatment of patients with carbon dioxide mineral water baths depend, in part, at least, on the absorption of carbon dioxide through the skin and its subsequent influence on the circulation and nervous system which occurs in the process of its natural elimination by way of the blood stream and the lungs.

As printed in American Heart Journal, Vol. 29, No. 1, Pages 41-61, January, 1945.

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MEDICAL NEWS

Births

TO DR. AND MRS. STANLEY C. CLADER, of Rosemont, a son, John Welch Clader, March 15.

TO DR. AND MRS. KARL C. JONAS, of Philadelphia, a son, Wayne Babcock Jonas, March 29. Mrs. Jonas is the daughter of Dr. and Mrs. W. Wayne Babcock, of Bala.

Engagements

MISS JOAN ANNETTE BAURSE to Leonard Bortin, M.D., both of Philadelphia.

MISS ANNE GENE HURST to Harry M. Madonna, M.D., both of Philadelphia.

MISS MARJORIE PATRICIA MCGUIRE, a graduate nurse, of Jeddo, to Robert W. McCoy, Jr., M.D., of Philadelphia.

MISS BARBARA ANN COULTER, daughter of Dr. and Mrs. John H. Coulter, to Mr. John R. L. Hihn, both of Philadelphia.

MISS SILVIA MARIE ROBERTS, daughter of Dr. and Mrs. Silvia J. Roberts, of Harrisburg, to Mr. Paul Edwin Herman, of Newberrytown.

MISS MARGARET MARY LOUGHERY, daughter of Dr. and Mrs. Thomas P. Loughery, of Jenkintown, to Mr. Robert Alfred Price, of Philadelphia.

MISS NORMA MARGARET ALESBURY, daughter of Dr. and Mrs. James M. Alesbury, of Philadelphia, to Mr. Edwin J. Kelley, of Syracuse, N. Y.

MISS EUGENIA EPLING DILLON, daughter of Dr. and Mrs. Edward S. Dillon, of Penn Valley, to Mr. Eric Alexander Pearson, Jr., of Philadelphia.

Marriages

MISS PATRICIA MEEHAN, of Philadelphia, to Mr. Jeremiah Jennings Sullivan, Jr., son of Dr. and Mrs. Jeremiah J. Sullivan, of Lancaster, May 20.

MISS ANNA LIDYA MARTUCCI, of Ardmore, to Mr. Ross Porter Skillern, son of Mrs. Ross Hall Skillern, of Ardmore, and the late Dr. Skillern, May 20.

MISS EMILY FOX DORRANCE, daughter of the late Dr. and Mrs. George M. Dorrance, of Philadelphia, to Mr. Henry C. Mayer, 4th, of Haverford, April 14.

MISS ELIZABETH COOK STELLWAGEN, daughter of Mrs. Thomas C. Stellwagen, Jr., of Lansdowne, and the late Dr. Stellwagen, to Dr. John Douglas McCurtain, of Cape Cod, Mass., April 15.

MISS DOROTHEA MILLER MANNING, of Norwood, to Capt. Charles Keally Liddell, U. S. Army Medical Corps, West Point, N. Y., April 22. Captain Liddell is a graduate of the University of Pittsburgh School of Medicine. He and Mrs. Liddell will reside in San Francisco.

MISS PATRICIA BLATT, of Chicago, Ill., to Howard E. Milliken, Jr., M.D., son of Dr. and Mrs. Howard E. Milliken, of Harrisburg, April 8, in Honolulu, Hawaii, where Dr. Milliken, Jr., is serving his residency and his bride is a supervising nurse at Queen's Hospital.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ **Albert J. Winebrake**, Scranton; Jefferson Medical College of Philadelphia, 1899; aged 75; died unexpectedly April 4, 1950, at his home. Dr. Winebrake took special training in gynecology and obstetrics at the University of Vienna and Rotunda Hospital, Dublin, Ireland, and founded the obstetrical department at the Lackawanna Hospital, now the Scranton State Hospital. Dr. Winebrake was a veteran of World War I and was wounded in action in France. He reportedly was the only Pennsylvania physician to serve in France with the A.E.F. at the same time his son was in combat there. In World War II he was civilian liaison agent for the Surgeon General's Office, Washington, D. C., and in 1944 made a six-week tour of military hospitals in several eastern states. He was invited to make the tour by Brig. Gen. George F. Lull, deputy surgeon general and Scranton native, now secretary of the AMA. Dr. Winebrake was greatly interested in young people who planned to study medicine. One of his proteges was Dr. Lull.

President of the Lackawanna County Medical Society in 1942 and secretary of the Board of Trustees at the time of his death, Dr. Winebrake was one of the most active members and as chairman of its Reception Committee never missed a meeting of the society in the 35 years in which he was a member. He had planned to attend a meeting the evening he died and word was received of his passing as the session began. Surviving are his widow, a son, and a daughter.

○ **Francis R. Packard**, Philadelphia; University of Pennsylvania School of Medicine, 1892; aged 80; died April 18, 1950. Dr. Packard was consulting otolaryngologist at the Pennsylvania Hospital and honorary keeper of its archives. He had been chief of otolaryngology from 1920 until 1931, when he retired, and had written a history of the venerable institution from 1751 to 1918. He was a former president of the College of Physicians, a member of the Philosophical Society, and had been associated with numerous library and literary groups. In 1942 Dr. Packard was given the Newcomb Award for scientific attainment in rhinology and laryngology. The award is the highest honor among nose and throat specialists in this country. He owned one of the largest medical libraries in the United States and was the author of many medical works and brochures, among which were: *History of Medicine in the United*

States, Diseases of the Ear, Nose and Throat, The School of Salerno, and Life and Times of Ambrose Pare. Dr. Packard was a former president of the American Laryngological Association and the American Otological Society, and a member of the American Laryngological, Rhinological and Otological Society and many other groups and organizations. He served in the Spanish-American War, also in World War I. Four daughters survive him.

CORRECTION

In the March, 1950 issue of the JOURNAL, the death of Dr. Wilbur J. Hawkins, Millsboro, was erroneously reported. It was his son, Dr. Wilbur J. Hawkins, Jr., who died and his obituary notice follows:

○ Wilbur J. Hawkins, Jr., Fredericktown; Jefferson Medical College of Philadelphia, 1933; aged 43; died Jan. 23, 1950.

○ John L. Atlee, Lancaster; University of Pennsylvania School of Medicine, 1900; aged 74; died April 3, 1950, following a major operation, when a tumor was removed from his esophagus. Dr. Atlee was a practicing surgeon for nearly half a century. Two sons, both of them surgeons and associated with their father, survive to carry on the tradition of the "Doctors Atlee" of Lancaster. There have been few times in the last 180 years when some member of the family was not serving in Lancaster as a physician. Dr. Atlee's grandfather, also Dr. John Light Atlee, was an organizer of the Lancaster County Medical Society, The Medical Society of the State of Pennsylvania (also president in 1857), and the American Medical Association (president in 1882). The Dr. Atlee, just deceased, was consulting surgeon to Lancaster General and St. Joseph's Hospitals for many years. He was at one time medical director of St. Joseph's Hospital, a post from which he retired a few years ago. He was a Fellow of the American College of Surgeons and a member of the American Association for the Surgery of Trauma. Besides his sons, Drs. John L. Atlee, Jr., and William A. Atlee, Dr. Atlee is survived by his widow and two daughters.

○ Stanley L. Freeman, Wilkes-Barre; University of Pennsylvania School of Medicine, 1910; aged 60; died in February, 1950. He had retired five years ago because of ill health. Dr. Freeman had served on the staffs of hospitals in Kansas City, Chicago, and New York, as well as in the Wyoming Valley. He was a former president of the Luzerne County Medical Society, and was a Fellow of the American College of Surgeons. During World War I, he served three years as an Army surgeon with the rank of captain. While on duty he was gassed and almost lost his eyesight. He was an outstanding citizen in his community and was highly regarded as a physician and surgeon.

○ Joseph D. Findley, Altoona; University of Pennsylvania School of Medicine, 1900; aged 73; died March 29, 1950. Dr. Findley was this year completing 50 years in the practice of medicine. He was chief of

staff of the Altoona Hospital since 1919; surgeon for the Pennsylvania Railroad; consulting surgeon at the State Tuberculosis Sanatorium at Cresson since 1912; also a past president of Blair County Medical Society. He was a Fellow of the American College of Surgeons. Surviving are his widow, one son, and three daughters.

○ Robert Boyer, Elkins Park; Medico-Chirurgical College of Philadelphia, 1898; aged 73; died April 15, 1950. Dr. Boyer was stricken with a heart attack while driving his car and died a short time later. He was on his way home from Nazareth Hospital, where he was a staff member. He was a Fellow of the American College of Surgeons and a member of the American Urological Association. Surviving are his widow, a son, and a daughter.

○ Edward E. Edwards, Taylor; University of Louisville School of Medicine, Kentucky, 1909; aged 66; died April 15, 1950, after an illness of three months. For many years he had served as physician for the Taylor schools, the Lackawanna Railroad, and two coal companies in addition to his private practice. Surviving are his widow, two brothers, one of whom is Vivian P. Edwards, M.D., of Edwardsville, and two sisters.

Clayton P. Struthers, Easton; Medico-Chirurgical College of Philadelphia, 1916; aged 59; died April 17, 1950, at the home of his son in Riegelsville. He had retired from practice in 1947. He had served on the staff of Easton Hospital for 22 years, and was a former member of the Northampton County Medical Society. He is survived by his widow and the son with whom he resided.

H. Winfield Boehringer, Philadelphia; Temple University School of Medicine, 1910; aged 71; died April 17, 1950. Dr. Boehringer was a former professor of ophthalmology at Temple University and served on the staff of Temple Hospital. From 1918 until 1945 he was on the medical staff of the Bell Telephone Company of Pennsylvania. Surviving are his widow, three sons, and a daughter.

H. Evert Kendig, Philadelphia; Medico-Chirurgical College of Philadelphia, 1905; aged 71; died April 18, 1950. In 1910 he obtained the degree of Doctor of Pharmacy at Temple University. He joined its faculty in 1907 as professor of pharmacy and public health in the School of Pharmacy and became dean in 1932. His widow and four daughters survive.

William L. Franck, Pottstown; Hahnemann Medical College and Hospital of Philadelphia, 1897; aged 74; died March 28, 1950. Dr. Franck had been chief of staff at Pottstown Memorial Hospital for several years during World War II and for a time was in charge of the x-ray work there. He was active in civic affairs. His widow and a sister survive.

○ Maurice B. Ahlborn, Wilkes-Barre; University of Pennsylvania School of Medicine, 1898; aged 73; died of a heart attack April 9, 1950. He was chief surgeon at Wilkes-Barre General Hospital until a few years ago, and was a Fellow of the American College of Surgeons. Surviving are his widow, a son, three daughters, and four sisters.

○Leo J. Wojczynski, Philadelphia; Jefferson Medical College of Philadelphia, 1911; aged 63; died April 18, 1950, after a short illness. He served as surgeon and chief gynecologist at St. Mary's Hospital and was on the staff of Nazareth Hospital. Surviving are two daughters, a brother, and a sister.

Arthur F. Wilhelm, Raubsville; Medico-Chirurgical College of Philadelphia, 1909; aged 71; died of a heart attack April 10, 1950, while treating a patient. The last of three generations to practice medicine, Dr. Wilhelm is survived by his widow, a daughter, two brothers, and five sisters.

Edwin Brown, Philadelphia; Jefferson Medical College of Philadelphia, 1884; aged 87; died April 10, 1950, in Abington Memorial Hospital. He was retired. He had been a ship physician for the American Steamship Line and the Munson Line. Two sons and two brothers survive.

○Charles V. Hepler, New Bethlehem; University of Pittsburgh School of Medicine, 1905; aged 68; died April 21, 1950. Dr. Hepler retired a year ago because of illness. He was a Pennsylvania Railroad physician for more than 25 years. Surviving him are two brothers and two sisters.

○Paul H. Kleinhans, Bethlehem; University of Pennsylvania School of Medicine, 1912; aged 61; died April 4, 1950. Dr. Kleinhans had been chief of the department of ophthalmology at St. Luke's Hospital since 1915. He is survived by his widow and a daughter.

William T. Moke, Pittsburgh; University of Pittsburgh School of Medicine, 1896; aged 73; died April 4, 1950, after practicing medicine for 53 years. He was a charter member of Phi Rho Sigma, national medical fraternity. His widow and two sons survive.

○Frank J. Briglia, Philadelphia; Jefferson Medical College of Philadelphia, 1928; aged 46; died April 5, 1950. He was a member of the American Academy of Ophthalmology and Otolaryngology. His mother is the only survivor.

○John R. Plank, Steelton; Jefferson Medical College of Philadelphia, 1896; aged 82; was found dead of a heart attack April 1, 1950. He is survived by his widow and a sister.

○Ruth L. Popp Mosch, Coudersport; University of Pennsylvania School of Medicine, 1946; aged 27; died Feb. 2, 1950.

Miscellaneous

THE SEVENTH ANNUAL MEETING OF THE AMERICAN GERIATRICS SOCIETY will be held June 1, 2, and 3 at the Hotel Commodore, New York, N. Y.

AT A RECENT MEETING OF THE BOARD OF TRUSTEES of the Philadelphia College of Pharmacy and Science,

Leonard D. Frescoln, M.D., of Philadelphia, was elected a trustee of the college.

J. HAROLD AUSTIN, M.D., of Philadelphia, who is retiring on June 30 as professor of research medicine in the University of Pennsylvania's School of Medicine, will become emeritus professor on that date.

RUSSELL F. MINTON, M.D., of Philadelphia, has been presented the Annual Achievement Award of the Philadelphia Club for his outstanding administration of Mercy-Douglass Hospital, where he has served as superintendent since 1949.

PETER A. VOLPE, M.D., formerly manager of the Veterans Administration Hospital in Dwight, Ill., has been appointed manager of the V-A Hospital in Aspinwall, Pa. Dr. Volpe succeeds Dr. Harold R. Lipscomb, who has been assigned to a position in the Department of Medicine and Surgery in the V-A Central Office in Washington, D. C.

FOUR PHILADELPHIANS ARE AMONG 26 SCIENTIFIC INVESTIGATORS engaged in research on tuberculosis who have been awarded grants by the National Tuberculosis Association. They are Drs. Max B. Lurie and Florence B. Seibert, of Henry Phipps Institute; Henry F. Lee, M.D., of Children's Hospital, and Charles Weiss, M.D., director of laboratories at Jewish Hospital.

THE THIRD ANNUAL POSTGRADUATE SEMINAR sponsored by the Hahnemann Medical College Alumni Association will be held on Tuesday, June 13, and Wednesday, June 14, at the college. The program will include seminar and panel discussions. Registrations should be made in advance by writing to Lees M. Schadel, Jr., M.D., general chairman, at the Alumni Office, 235 N. 15th St., Philadelphia 2, Pa.

THE REGIONAL FRACTURE COMMITTEE IN PITTSBURGH met at the Pittsburgh Athletic Club, Thursday, April 13. The program included presentation of fracture problems by members or visitors with presentation of x-rays or patients, followed by an address by Dr. Edward L. Compere, of Chicago, on the subject, "Segmental Fractures of Long Bones." Dr. Wilton H. Robinson was chairman; Dr. Scott A. Norris, secretary.

THE MEDICAL ALUMNI SOCIETY OF THE UNIVERSITY OF PENNSYLVANIA is planning to hold medical and surgical clinics at the University Hospital, Philadelphia, from 9:30 a.m. to 11:30 a.m. on Alumni Day, June 17. Following the clinics the society will hold a luncheon at 12:00 noon at the Penn-Sheraton Hotel, 39th and Chestnut Streets. For further information, communicate with Miss Frances R. Houston, Executive Secre-

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THE SOCIETY FOR INVESTIGATIVE DERMATOLOGY

will hold its

ELEVENTH ANNUAL MEETING

at the Clift Hotel, San Francisco, California

on Sunday, June 25, 1950

(See *Archives of Dermatology and Syphilology*,
May, 1950, for Scientific Program)

tary, Medical Alumni Society, at the School of Medicine.

THE DIRECTORY ISSUE OF *Graphics*, the official publication of the Association of Medical Illustrators, contains the name, address, training, professional experience, and reference to major published work of each member. Other information pertaining to the profession is included. The journal, to be issued on June 1, will be available to those requiring medical illustration service, and will be sent free of charge upon request to the editor, Miss Helen Lorraine, 5212 Sylvan Road, Richmond 25, Va.

JOHN V. BLADY, M.D., associate professor of surgery at the Temple University Medical School, Philadelphia, has been named to receive the 1950 award of the American Cancer Society for outstanding work in the field of cancer control in this area. Dr. Blady, who is director of the tumor clinic at Temple University Hospital, was chosen for the award in recognition of his control and education programs as chairman of the cancer control committee of the Philadelphia County Medical Society and in cooperation with the American Cancer Society.

THE TENNESSEE COAL, IRON AND RAILROAD COMPANY, a United States Steel Corporation subsidiary, in dedicating its employees' hospital recently at Fairfield, Ala., honored the name and memory of Lloyd Noland, M.D., for many years its chief surgeon. Dr. Noland, in addition to his career in industrial medicine, served or-

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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, *Am. J. M. Sc.* 209: 33-41 (Jan.) 1945.

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ganized medicine with distinction in county, state, and national medical societies. Many Pennsylvanians will remember him in the House of Delegates of the American Medical Association, from Alabama, and as a member of the AMA's Judicial Council.

THE APPOINTMENT OF DR. GLIDDEN L. BROOKS as co-ordinator of the Medical Center Hospitals and Clinics and professor of hospital administration at the University of Pittsburgh has been announced by Chancellor R. H. Fitzgerald. Dr. Brooks was nominated by a special committee under the chairmanship of Mr. J. Steele Gow, chairman of the Board of Trustees of the Children's Hospital. Other members of the committee were Deans William S. McElroy and Thomas Parran, and Mr. A. W. Schmidt. In addition to co-ordinating the services of the Medical Center hospitals, Dr. Brooks will be responsible for developing the courses in hospital administration in the Graduate School of Public Health. Pittsburgh is a natural center for the development of these courses, which will train future administrators of hospitals.

THE COMMITTEE ON MEDICAL MOTION PICTURES OF THE AMERICAN MEDICAL ASSOCIATION has completed the second revised edition of the booklet entitled *Reviews of Medical Motion Pictures*. This booklet now contains 225 reviews of medical and health films reviewed in *The Journal A.M.A.* to Jan. 1, 1950. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief descrip-



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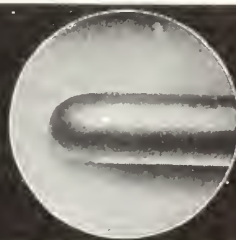
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THE SIXTEENTH ANNUAL MEETING OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS will be held at the St. Francis Hotel, San Francisco, Calif., June 22 through 25, 1950. An interesting scientific program has been arranged for the meeting.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in San Francisco, June 22, 1950. Candidates for Fellowship in the College who would like to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn St., Chi-

cago 10, Ill. Burgess Gordon, M.D., Philadelphia, serves as the governor of the College for the State of Pennsylvania. Edward Lebovitz, M.D., Pittsburgh, is the residing president of the Pennsylvania Chapter.

METHODIST HOSPITAL, Philadelphia, and Jefferson Medical College and Medical Center have signed an agreement of affiliation under which they will merge and exchange certain of their facilities while each institution maintains its independent status, it was announced April 27. The affiliation will be similar in nature to that which has been in operation between Jefferson and Germantown Hospitals since last June 22. Under it, Methodist Hospital will remain a sectarian institution, related to and supported by the Methodist Church. Under the agreement, Methodist Hospital will make its ward facilities and staff available for clinical teaching use by Jefferson Medical College, while Jefferson in turn will help to provide additional house staff physicians and specialists for Methodist Hospital.



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For Rent.—Doctor's offices for rent because of death. Well established practice. Excellent opportunity. Write MRS. C. W. SCHWALM, Shoemakersville, Pa.

For Sale.—American College of Surgeons robe and hat, worn only once. Price reasonable. Write Dept. 196, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Radiologist, board eligible, well trained in diagnosis and therapy, desires an appointment where high standards of radiology are practiced. Write Dept. 191, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Locum tenens.—Young Navy physician desires position for July, August, and September. Pennsylvania license. Write Dept. 192, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Locum tenens for six weeks—August 30 to October 15. Pennsylvania license. Car and living quarters furnished if necessary. Write Dept. 194, PENNSYLVANIA MEDICAL JOURNAL.

General Residency.—To start July 1, 1950; salary open; 346-bed general hospital, approved by the American College of Surgeons. Apply to SUPERINTENDENT, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

Wanted.—Otolaryngological resident for Episcopal Hospital, Philadelphia, Pennsylvania, beginning July 1, 1950. For details write OTTO C. HIRST, M.D., Episcopal Hospital, Philadelphia 25, Pa.

Wanted.—Physician with Pennsylvania license for full-time institutional work. Excellent professional facilities. Living quarters for family optional. Write Dept. 189, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Location as radiologist in small hospital. Diplomate of American Board as of 1939; 20 years' experience; available in 15 days. Write Dept. 197, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Assistant for well-established general medical practice within ten miles of Pittsburgh. Salary open to well-qualified man. Write giving details and when available to Dept. 190, PENNSYLVANIA MEDICAL JOURNAL.

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For Sale.—Established general practice in northeastern Pennsylvania manufacturing town. Four room office suite, fully furnished and equipped. Centrally located. Price of equipment covers all. Specializing. Write Dept. 195, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Resident house physician, male or female, licensed to practice in Pennsylvania or eligible for reciprocity; 202-bed general hospital. Apply to JANE M. BOYD, ADMINISTRATOR, Butler County Memorial Hospital, Butler, Pa.

House Physician Wanted.—Grand View Hospital, of Sellersville, wishes to employ a house physician. Give references, experience, and salary desired in first communication. Write SUPERINTENDENT, Grand View Hospital, Sellersville, Pa.

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Wanted.—Resident physician, July 1, or later in 1950, single or married, for general medical and surgical hospital. Approved by A.C.S. Near Wilkes-Barre. Excellent salary and duty schedule. Attractive living quarters. Further particulars furnished. Write SUPERINTENDENT, Nanticoke State Hospital, Nanticoke, Pa.

For Sale.—Combination home and office in community of 10,000 people. General practice established 35 years. Located in northeastern Pennsylvania. Chief industries are railroads, manufacturing, and farming. Open-staffed hospital. Retiring. Write DEPT. 187, PENNSYLVANIA MEDICAL JOURNAL.

Residents and Interns Wanted.—Resident physician with Pennsylvania license. Salary \$400 per month with full maintenance. Interns—salary \$200 per month with full maintenance. 191-bed general hospital. Fully approved by A.C.S. Write ADMINISTRATOR, Hahnemann Hospital, Scranton, Pa.

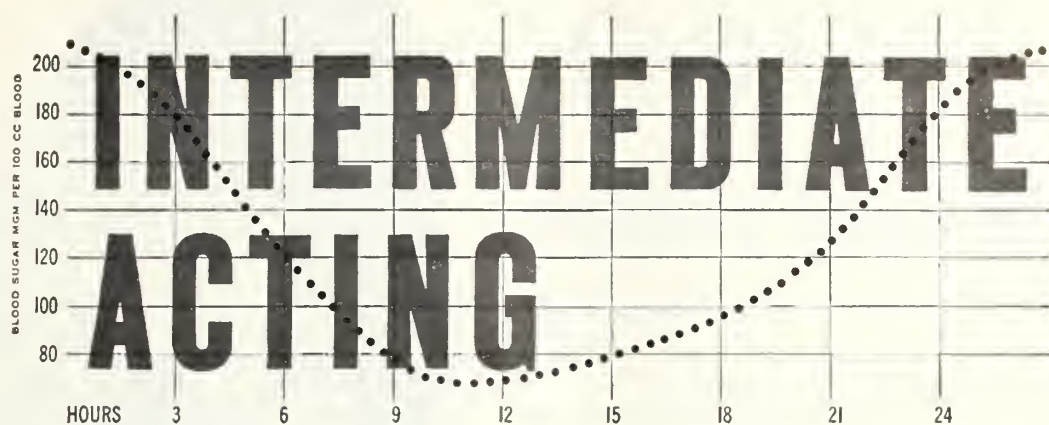
For Sale.—General practice with all supplies and equipment for price of equipment alone: Includes 100 KV, 100 MA X-ray and fluoroscopic unit with all accessories. Office suite of six rooms in central location of small industrial community 30 miles west of Philadelphia. Price, \$5,000. Write Dept. 183, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Fully equipped modern office of recently deceased young physician. Practically new 100 M.A. X-ray (G. E.), two Whirlpool Baths, diathermy, laboratory equipment, waiting room and office furniture. Well established practice in thriving mining community. Contact or write MRS. WILBUR J. HAWKINS, JR., P. O. Box 487, Fredericktown, Pa.

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Wanted.—Staff physician for 105-bed private tuberculosis sanatorium, central Pennsylvania. Medical and surgical phases covered, including bronchoscopy; outpatient service. Excellent opportunity to learn. Pennsylvania license or reciprocity required. House and maintenance for physician and family; congenial surroundings. Inquire MEDICAL DIRECTOR or SUPERINTENDENT, Devitt's Camp, Allenwood, Pa.

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1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



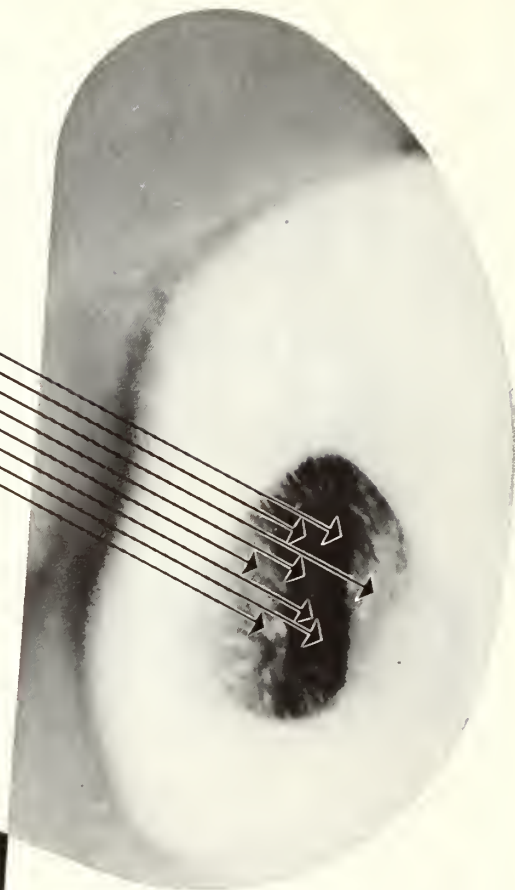
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BOOK REVIEWS

A Century of Medicine in Jacksonville and Duval County. By Webster Merritt, M.D. 220 pages with 44 illustrations. Gainesville, Fla.: University of Florida Press, 1949. Price, \$3.50.

Physicians and laity alike will find in this engaging narrative a most important contribution to Florida's medical and historical lore. With the sure and forthright touch of the true historian, Dr. Merritt presents in panoramic review the fascinating events, towering personalities, and progressive movements of the entire nineteenth century as they pertain to medicine in Jacksonville and Duval County. His exhaustive research and painstaking efforts have brought to light in highly readable form history long obscured, owing to loss of official records in the Jacksonville fire of 1901. In sifting out the facts for this entertaining and accurate account, he pictures the physician as community builder and harbinger of progress as well as practitioner of medicine, and his facile pen loses none of the drama of the terrifying yellow fever and other epidemics or the gala events of the times. With equal skill he traces the foundation and early history of the Florida Medical Association and of the Florida State Board of Health.

Handbook of Medical Management. By Milton Chatton, A.B., M.D., Instructor in Medicine, University of California Medical School, San Francisco; Sheldon Margen, A.B., M.D., Clinical Instructor in Medicine and Research Associate in Medicine, University of California Medical School; and Henry D. Brainerd, A.B., M.D., Assistant Clinical Professor of Medicine and Pediatrics, University of California Medical School; Assistant Clinical Professor of Pediatrics, Stanford University School of Medicine; Physician-in-Charge, Isolation Division, San Francisco Hospital. First edition. Palo Alto, Calif.: University Medical Publishers, 1949. Price, \$3.00.

This is the first edition of an inexpensive abstract of medical management for the use of student and practitioner. The authors plan to revise this handbook each year and thus provide the new along with the accepted and timely procedures. No claim has been made that it will provide assistance in diagnosis, but helpful comments and charts showing differential diagnostic points of interest are included. In addition, provision has been made to facilitate the coding of diseases by using code numbers from the Standard Nomenclature of Disease

and Standard Nomenclature of Operations of the American Medical Association.

Reference is remarkably easy and some tables of normals are available. The suggestions for the general care of patients are particularly good. Controversial issues have been minimized. Generally accepted régimes are recorded. Despite the size, many details have been included. If space permitted, pertinent references would be of value.

This is a practical, well-organized handbook which will be quite popular.

Visual Development, Volume I. By J. H. Prince, F.R.M.S., F.Z.S., F.B.O.A., F.S.M.C., Late Regional Association Lecturer in Comparative Ocular Anatomy and Ocular Evolution. 418 pages with 190 illustrations and 10 tables. Baltimore, Md.: The Williams & Wilkins Company, 1949. Price, \$9.50.

The pages of this book are full of new and absorbing information for the reader. However, it is believed that this book will probably interest only a comparatively few persons.

The purpose of the author was to record his concepts of certain aspects of vision and to stimulate others to work in the field of experimental optics and experimental naturalism. This he presents as follows: Part 1 of the book is devoted to the mechanisms of vision and what constitutes perception in man and animals. This is covered in this sequence: photo-reception, perception, retinal structure in man, retinal structure in animals, photochemical aspects, retinal stimulation quanta. Part 2 builds a picture of evolutionary development throughout the ages, the sequence being evolution (invertebrate), evolution (vertebrate), nocturnality, pupillary function, sensitivity of bacillary layer, tapeta, sightless vertebrates. Part 3 is devoted to color vision, its development in animals and defects in man. Part 4 is an elaboration of the author's thesis on "night vision," discussing dark adaptation and tests and the association of nystagmus with retinal defects. Part 5 is essentially an attempt to encourage would-be experimenters to extend their interest to this field and includes a chapter on fundus significance. A glossary, bibliography, and an index complete the book.

For the limited few for whom this book appears to have been written, it is believed that it will be interesting.

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BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Compulsory Medical Care and the Welfare State. By Melchior Palyi. An analysis based on a special study, sponsored by the National Physicians Committee of Governmentalized Medical Care Systems on the Continent of Europe and in England. Chicago, Ill.: National Institute of Professional Services, Inc., 1950.

Coagulation, Thrombosis, and Dicumarol. With an Appendix on Related Laboratory Procedures. By Shepard Shapiro, M.D., Assistant Professor of Clinical Medicine, New York University College of Medicine; Visiting Physician, Third (New York University) Medical Division, Goldwater Memorial Hospital; Associate Physician, Lincoln Hospital; and Murray Weiner, B.S., M.S., M.D., Fellow in Medicine, New York University College of Medicine; Research Assistant, Third (New York University) Medical Division, Goldwater Memorial Hospital; Assistant Visiting Physician, Willard Parker Hospital Chest Service; Clinical Assistant Visiting Physician, Bellevue Hospital. New York: Brooklyn Medical Press, 1950. Price, \$5.50.

Postgraduate Gastroenterology. As presented in a course given under the sponsorship of the American College of Physicians in Philadelphia, December, 1948. Edited by Henry L. Bockus, M.D., Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine. Philadelphia: W. B. Saunders Company, 1950. Price, \$10.00.

Lord Lister—His Life and Doctrine. By Douglas Guthrie. Baltimore: The Williams & Wilkins Company, 1949. Price, \$3.50.

The Cytologic Diagnosis of Cancer. By the staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital. A gynecologic service affiliated with the Massachusetts General Hospital, Boston, Mass., and the Department of Gynecology, Harvard Medical School. Published under the sponsorship of the American Cancer Society. Philadelphia: W. B. Saunders Company, 1950. Price, \$6.50.

Public Health Is People. By Ethel L. Ginsburg. An institute on mental health in public health held at Berkeley, Calif., 1948. New York: The Commonwealth Fund, 1950. Price, \$1.75.

Urological Surgery. By Austin Ingram Dodson, M.D., F.A.C.S., Richmond, Va., Professor of Urology, Medical College of Virginia; Urologist to the Hospital Division, Medical College of Virginia, to Crippled Children's Hospital, to St. Elizabeth's Hospital, and to St. Luke's Hospital and McGuire Clinic. Second edition with 645 illustrations. St. Louis: The C. V. Mosby Company, 1950. Price, \$13.50.

Physicians' and Nurses' Concise Medical Encyclopedia. By William H. Kupper, M.D., author of *Malarial Therapy of Paresis, State and National Board Summary, Interesting and Useful Medical Statistics*. Los Angeles, Calif.: Biblion Press, 1950. Price, \$7.50.

Penicillin. Its Practical Application. Under the general editorship of Professor Sir Alexander Fleming, M.B., B.S., F.R.C.P., F.R.C.S., F.R.S., Professor

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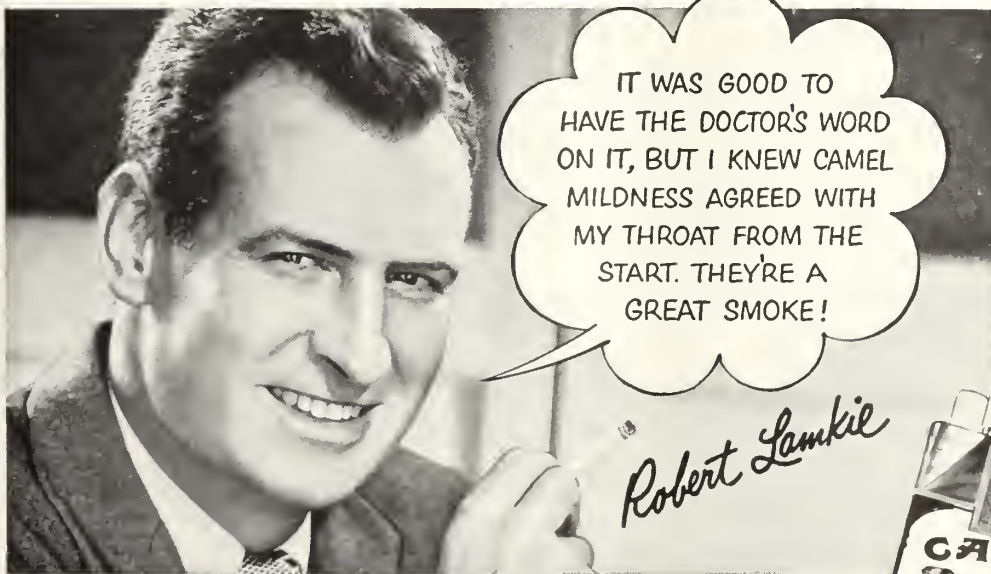
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Emeritus of Bacteriology, University of London; Principal, Wright-Fleming Institute of Microbiology, St. Mary's Hospital Medical School, London. Second edition. St. Louis: The C. V. Mosby Company, 1950. Price, \$7.00.

A Manual of Cardiology. By Thomas J. Dry, M.A., M.B., Ch.B., M.S., in Medicine, Associate Professor of Medicine, University of Minnesota (Mayo Foundation); Consultant in Section on Cardiology, Mayo Clinic. Second edition, illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$5.00.

Medical Gynecology. By James C. Janney, M.D., F.A.C.S., Associate Professor of Gynecology, Boston University School of Medicine; Associate Visiting Gynecologist, Massachusetts Memorial Hospitals. Second edition, illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$6.50.

Progress in Clinical Endocrinology. Edited by Samuel Soskin, M.D., Director, Medical Research Institute, Michael Reese Hospital, Chicago, Ill.; Dean, Michael Reese Hospital Postgraduate School; Professorial Lecturer in Physiology, University of Chicago. New York: Grune & Stratton, 1950. Price, \$10.00.

Handbook of Obstetrics and Diagnostic Gynecology. By Leo Doyle, M.S., M.D. First edition. Illustrations by Ralph Sweet. Palo Alto, Calif.: University Medical Publishers, 1950. Price, \$2.00.

Saw-Ge-Mah (Medicine Man). By Louis J. Gariepy, M.D. St. Paul, Minn.: Northland Press, 1950. Price, \$3.00.

A Guide to General Medical Practice. By Martin G. Vorhaus, M.D., Attending Physician, Hospital for Joint Diseases, New York City. New York: The Macmillan Company, 1950. Price, \$3.50.

Proceedings of the First Clinical ACTH Conference. John R. Mote, M.D., editor. Philadelphia: The Blakiston Company, 1950. Price, \$5.50.

IS SOCIAL SECURITY SYSTEM FINANCIALLY UNSOUND?

Newspaper Uses AMA Study as Basis of Editorial. A speech entitled "Social Morality and the Cradle-to-the-Grave Philosophy" which Frank G. Dickinson, Ph.D., director of the AMA Bureau of Medical Economic Research, delivered last November at a University of Wisconsin meeting served as the basis of a lengthy editorial which appeared recently in the *Miami Herald*.

In his speech, Dr. Dickinson said in essence that older people have the necessary voting power to fasten themselves on the pay checks of youth.

After stating that "there is no financial sense to the current Social Security system," the *Herald* editorial said: "It may surprise American youth to be told that the old folks upon whom they look with tolerance, if not always with kindly consideration, are a potential menace to their financial future. . . . Younger Americans should not let their elders use their developing political strength to saddle back-breaking burdens on today's youth and on their children."

"It may not be long before the lawyers will find themselves shoulder to shoulder with the doctors in a fight against socialization. England, after several years of government medicine, now proposes to establish a form of government-supported legal service.

"The English plan is contained in a legal aid and advice bill, presented in November to Parliament by the Lord High Chancellor. It will probably be enacted by the Socialist majority without much delay."—RAYMOND MOLEY in *The Columbus Dispatch*.

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Woman's Auxiliary Department

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Officers' Department

Dermatitis and Fabrics

Louis Schwartz

Crime and Punishment

An Editorial

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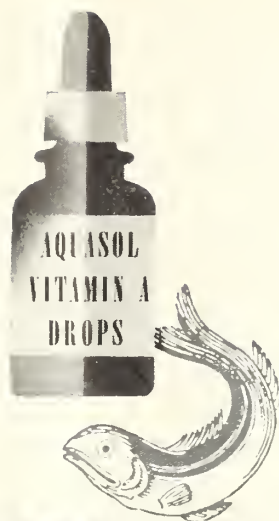
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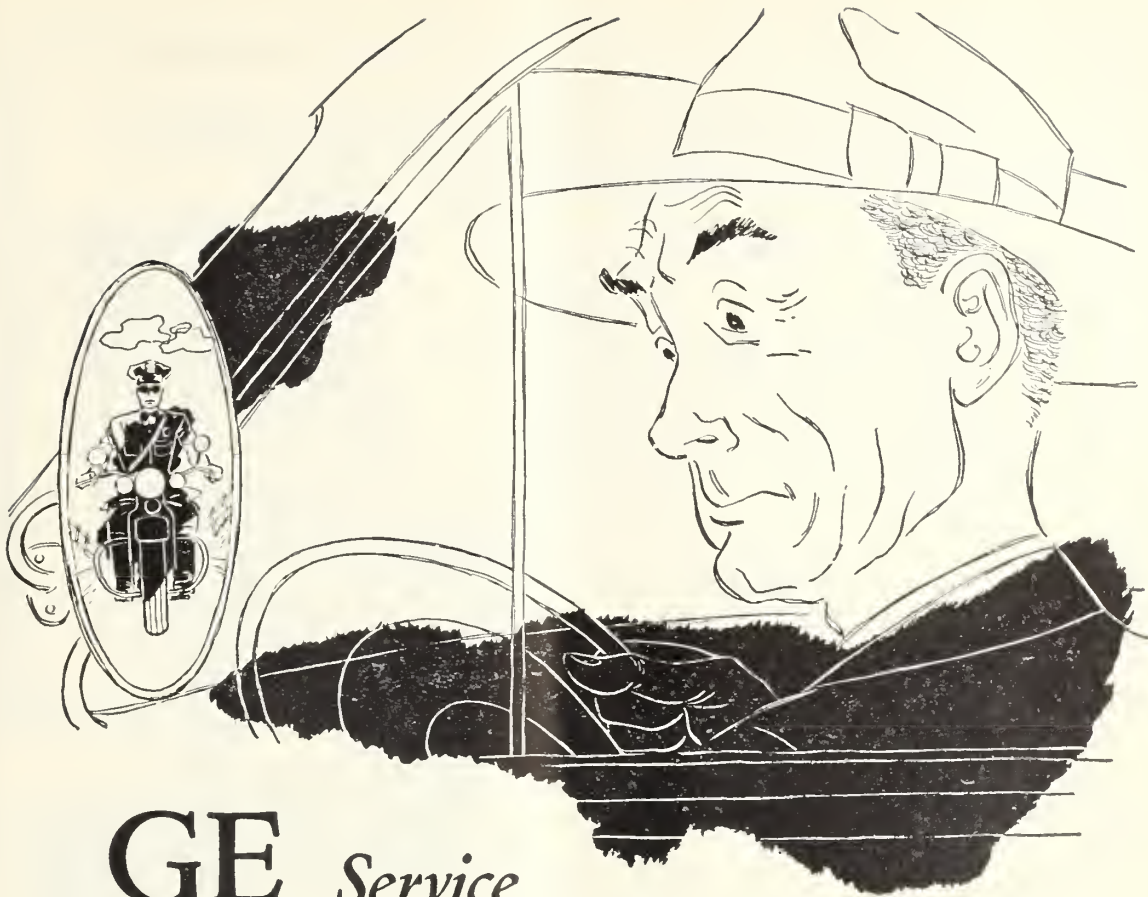
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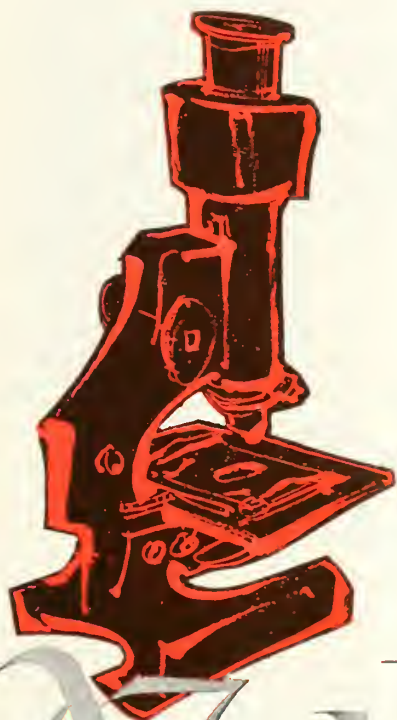
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THE *Pennsylvania* MEDICAL JOURNAL

Volume 53

JUNE, 1950

Number 6

DERMATITIS AND FABRICS

LOUIS SCHWARTZ, M.D.

Washington, D. C.



WHEN we consider that practically all the people on earth wear fabrics, the percentage of people affected by them is almost infinitesimal.

Occasionally there are comparatively large outbreaks of dermatitis which can be

traced to one chemical used on a fabric. Such an outbreak occurred in 1941 when ester gum used as a fabric finish caused dermatitis among hundreds of wearers of stockings, shorts, pajamas, and other wearing apparel treated with the particular finish.

Dermatitis is rarely caused by fabrics themselves. It is usually caused by some chemical with which the fabric is treated.

Fibers from which fabrics are made may be classified according to derivation into vegetable, animal, and synthetic.

Vegetable Fibers

Cotton
Flax (*Linum usitatissimum*)
Hemp (*Cannabis sativa* and *C. indica*). Manila hemp (abaca)
Jute (*Corchorus olitorius* and *C. capsularis*)
Pina cloth (pineapple leaves)
Sisal (*Agave sisalina*. Henequen leaves. Yucatan)

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 27, 1949.

Occupational dermatitis occurs among the workers (retters and hecklers) who prepare the fibers from the plants. It is caused in most instances by the cutting effect of the fibers on the water-soaked, macerated skin of the hands. Mechanical irritation of the face, neck, and other exposed parts by the lint and dust may also occur. A rare worker may have a true allergic dermatitis from any of these plants.

Occupational respiratory diseases such as byssinosis, flax-dressers' disease, and mill fever (from hemp) have been reported.

Animal Fibers

Silk (<i>Bombyx mori</i>)	Cashmere (Kashmir goat)
Wool (sheep)	Vicuna cloth (<i>Lama vicuna</i>)
Camel's hair (camel)	Felt (rabbit)

Occupational dermatitis among silk winders is not uncommon. It is usually caused by the hot alkaline solutions in which the cocoon is immersed in order to unwind the silk filament. The fingers and hands are affected by a dermatitis resembling housewives' eczema. A small percentage of the cases of silk winders' dermatitis is caused by sensitivity to the decomposition products of the dead chrysalis, burrowing parasites in the cocoons, barbed particles and hairs from the worm, and perhaps some irritant venom in the spines. Allergic dermatitis from sensitivity to the silk protein itself occurs but rarely.

Silk throwsters' dermatitis is usually caused by the soaps and anti-mildews used in the throw-

ing solutions. It usually affects the dorsum of the hands of reelers who spread the wet reels with their hands.

Wool is derived mostly from sheep. Other sources are camel's hair, goat hair, alpaca, llama, and vicuna.

Dermatitis among sheep-shearers occurs from the antiseptic solutions into which the sheep are dipped before shearing. Allergic sensitivity to wool is rare. Raw wool handlers, however, are subject to anthrax, mycoses of the hands, and respiratory allergy from the wool and hairs of the animals from which wool is derived.

Workers processing wool into fabrics often have dermatitis. The scourers of wool may be affected by the soaps and solvents used for this purpose. Wool dyers may have dermatitis from the acid wool dyes and the chrome mordants. Wool spinners may have oil acne, oil keratoses, and skin cancers (England) from the oils used to lubricate the spinning machines.

Felt is a fabric made principally from the fur of the rabbit and hare, but scrap fur from the muskrat, nutria, beaver, squirrel, etc., is also used.

Fur must be carroted before it can be made into felt. The carroting solutions may be mercuric nitrate or strongly alkaline solutions, and carroters and felt makers are subject to dermatitis of the hands and arms from the irritant carroting solutions.

Mercurialism is not uncommon among workers exposed to the mercurial carrots.

Felt is dyed with chrome dyes and these may cause dermatitis. The alkalis used to stiffen felt may also cause dermatitis.

Synthetic Fabrics

The principal synthetic fabrics on the market are rayon (regenerated cellulose), celanese (cellulose acetate), and nylon (said to be hexamethylene diamine adipate). Other synthetic fabrics less frequently used are made of de-nitrated cellulose nitrate, such as vinyon (copolymer of vinyl chloride and vinyl acetate). Glass is also made into fabrics, but the glass fabrics are not yet used as clothing. Nevertheless, there was an outbreak of dermatitis caused by glass fabric being used for coat lining when other lining material was scarce and expensive.

There are a number of occupational skin hazards in the manufacture of rayon: dermatitis and burns from alkalis and sulfuric acid; conjunctivitis (called fume eyes) from the hydrogen

sulfide and carbon bisulfide coming out of the acid baths; and dermatitis of the hands and arms from the finishing oils used on the thread.

In the manufacture of celanese there are occupational skin hazards from acetic acid and from the finishing oils used in spinning, twisting, and coning.

The manufacture of glass fabrics has skin hazards from the mechanical cutting of the skin by sharp thread; from the resins used on the glass filaments in order to bind them into threads; and from sharp glass slugs and resin contained in "glass wool."

There are no reports of dermatitis in the manufacture of nylon.

Dermatitis from Wearing Fabrics. As stated before, the finished fabrics are among the least noxious substances with which we come in contact. However, there is scarcely any substance, however innocuous, to which some rare person may not be hypersensitive. Even in the year of 1941 when there was an unusual outbreak of dermatitis among the public caused by a particular finish used on stockings, shorts, pajamas, dresses, etc., reports from 110 stores belonging to the National Retail Dry Goods Association showed only 486 complaints of dermatitis from wearing apparel.

Although there are occasional reports of skin sensitivity to wearers of silk, wool, and fur, the unprocessed synthetic fibers have not been incriminated. In reported cases attributed to "rayon," the finished fabric was meant, and when "nylon" was reported as causing dermatitis the resin finish on the nylon and not the nylon itself was shown to be the actual cause.

The principal causes of dermatitis from fabrics used for wearing apparel have been shown to be the dyes, mordants, and finishes.

Dyes

Some years ago it was the common impression among physicians that most of the dermatitis from wearing fabrics was caused by the so-called aniline dyes and that the aniline dyes were powerful skin irritants. When we consider the fact that nearly all of the people in the civilized world wear fabrics processed with synthetic dyes (which is a better name than aniline dyes), the percentage of people affected by them is almost infinitesimal.

When dermatitis is actually due to a dye in the fabrics, it is due to allergy or idiosyncrasy to the

dye or to a faulty dyeing process. The dyes on fabrics are rarely if ever primary skin irritants.

When idiosyncrasy to the dyes is the actual cause of dermatitis, it is usually found that the dyes "bleed." Conditions on the skin may be partly responsible for bleeding. For instance, some dyes will bleed in highly acid perspiration while others will do so in alkaline perspiration. Some dyes will bleed on an oily skin. Under certain conditions of heat, as in ironing, some dyes may decompose into irritant intermediates.

Free mordants and oxidizing agents, such as the alkaline bichromates remaining on the fabric because they are used in excess and not properly washed off, may cause dermatitis.

Special dyes used for dyeing rayon and nylon may cause dermatitis. Some of the yellow, orange, and red azo dyes used on nylon hose have recently been reported as having caused dermatitis.

The following is a list of dyes used on fabrics that I have found may be causes of dermatitis:

Amino-azo-benzine	Malachite green
Amino-azo-toluene	Metanil yellow
hydrochloride	Methyl violet
Aniline black	Orange R.
Auramine	Orange Y.
Brilliant indigo 4G	Paraphenylene diamine
Chrysoidine	Ponsol dark blue B. R.
Chrystal violet	Safranine
Hydron blue	Sulphanthrene pink F. F.
Indanthrene violet R. R.	Victoria blue
Ionamine A.	Victoria green
Iso-rosinduline	

Baer reported the following dyes as having caused dermatitis:

Yellow	p-amino acetanilide→p-chlorphenol
Red	p-nitro aniline→ethyl hydroxy ethyl aniline

Fleming found the following dyes capable of causing sensitization dermatitis:

Yellow	p-amino acetanilide→p-cresol
Orange	p-nitro aniline→p-xylydine
	p-nitro aniline→aniline
Red	Mixture of: p-nitro aniline→ethyl hydroxy ethyl aniline, and O-chlor-p-nitro, aniline →ethyl hydroxy, ethyl aniline
Blue	Mixture of: 1-methyl amino — 4(hydroxy-ethylamino) anthraquinone and 1, 4-di (hydroxy-ethylamino) anthraquinone

Fabric Finishes

In most instances dermatitis from wearing of fabrics is caused by the finishes rather than the dyes or the fabric itself.

Finishes are placed on fabrics to give them a better appearance such as luster, better feel, or better wearing properties; to prevent runs and

unraveling; to make fabrics non-creasing; to hold the crease; to make them waterproof, moth-proof, flameproof, moldproof, and insectproof. Some finishes stay more or less permanently in the fabric. Others are easily removed by the laundering and only a small part may remain after many washings.

Starches and sulfonated castor oil were the first finishes used and were applied to enhance the appearance and the feel of the fabric and thus increase its selling appeal. Dermatitis has never been reported from starch, but I have shown elsewhere that an improperly neutralized sulfonated castor oil (alkalinity) was a cause of a dermatitis from socks.

More recently certain resins have been applied as finishes to make the fabric resistant to wrinkling or to hold its crease and in the case of stockings to prevent runs. These resins are usually applied in the dye bath and consist of modified natural or synthetic resins. An outbreak of dermatitis thought at first to be due to nylon hose was really due to a finish containing an ester gum. This finish was also used on cotton shorts and pajamas and caused dermatitis.

The new synthetic resin finishes have caused a number of cases of dermatitis. The resins are applied from solutions or emulsions which leave a thin film of the resin on the fabric after evaporation of the solvents. The heat of subsequent operations such as drying or boarding is relied upon to completely cure the resin finish. Sometimes a complete cure does not take place.

Completely cured resins do not as a rule cause dermatitis. When complete polymerization and stabilization do not occur, there may be enough free monomers or uncured resins remaining on the fabric to cause dermatitis in sensitive cases. I have recently had in my consultation practice a case of dermatitis involving the penis caused by the finish on a certain brand of rayon shorts.

Waterproof Finishes

In some of the older methods of waterproofing fabrics, the fabric was placed in the soap bath followed by alum or other aluminum salts in watery solution in order to deposit aluminum soap on the fabric, or an application of aluminum or lead soap from an organic solvent such as benzene was made. There are no recorded cases of dermatitis from waterproofing agents consisting of insoluble metallic soaps.

In still another method of waterproofing, the fabric after dyeing and drying is then passed

through a solution of paraffin dissolved in a petroleum solvent and again dried over hot cylinders. When Japan wax was used instead of paraffin, dermatitis was seen from such coated fabrics because Japan and China wax is derived from a tree of the poison ivy family (*Rhus verniciflua*).

Flameproofing Finishes

Cotton and silk are flameproofed by treating with chlorinated naphthalenes, ammonium sulfate, boric acid and borate, di-ammonium phosphate, antimony chloride, or other flameproof substances. Although dermatitis sometimes develops in workers making these materials and chloracne may develop in workers processing fabrics with chlorinated naphthalenes, cases of dermatitis among the users of these fabrics have not been reported.

Delustering Agents

Zinc sulfate, barium sulfate, aluminum sulfate, and titanium oxides are some of the chemicals used as delustering agents. No dermatitis has been reported from their use.

Mothproofing and Lousicides

Silicofluorides are most frequently used for mothproofing, although naphthalene, chloronaphthalenes, chlorobenzenes, chlorophenols, synthetic camphor, and others are also used. The solutions of silicofluorides are usually sprayed on the fabrics. The silicofluorides may cause dermatitis. The naphthalenes and camphor used in the form of flakes or balls are placed in the clothes or closets. Dermatitis has not been reported from fabrics exposed to camphor and naphtha balls. Dermatitis may be caused by chloronaphthalenes, chlorobenzenes, and chlorophenols.

Since the outbreak of World War II, it has been found desirable for sanitary reasons and as a protective measure against typhus to treat clothing of our armed forces with chemicals known to kill lice and other related insects. The most widely used and effective agent at present is DDT (dichlorodiphenyl trichloro-ethane). It can be used alone or in combination with other insecticides. DDT can cause allergic dermatitis. Other insecticides such as pyrethrum, rotenone (the active principle of derris and cube), and synthetic insecticides may be used.

The synthetic insecticides are usually primary irritants in strong concentrations and may also be sensitizers. The natural insecticides are sensitizers, but not primary irritants.

Anti-mildews

With the advent of the war it was found necessary to mildewproof many articles of clothing and equipment made of fabric and leather to prevent their deterioration in tropical climates. Tenting, hammocks, camouflage and mosquito netting, knapsacks, canvas covers of all types, leather and interlinings of shoes, and many other articles have been treated with mildewproofing agents. They are so precipitated on the fabrics that they will be retained after many washings. While many chemicals are excellent fungicides, they cannot safely be incorporated into articles of clothing or equipment which are to be in close contact with the skin because they are primary skin irritants and sensitizers in the concentrations in which they satisfy anti-mildew performance specifications. Even if such irritant chemicals are incorporated into materials which are not to be in contact with the skin, such as sandbags and tenting, they have been the causes of dermatitis to some workers making those materials. This does not imply that such chemicals should not be used in fabrics which will not be worn next to the skin. It may even be possible to effectively use for certain anti-mildew purposes such low concentrations of irritant anti-mildews as will irritate the skin of only exceptionally susceptible persons.

There is no single anti-mildew that can be said to be the best under all conditions. The choice depends on the material to be protected, the use to which the material is to be put, and the conditions of storage before the material is used. For instance, some anti-mildews work better than others on leather or on certain fabrics. Some anti-mildews withstand weathering better than others. Some withstand soil burial better than others. Some have less deleterious action on certain fabrics. Some will leach out of materials faster than others. Some are more irritant to the skin than others. All these facts should be considered by a manufacturer in selecting the anti-mildew best suited for his purposes. It may be necessary to use a combination of two or more anti-mildews to attain the desired effect.

There are scores of anti-mildews, but the following is a list of those most widely used:

Copper naphthenate	Pyridyl mercuric compounds
Zinc naphthenate	Phenyl mercuric compounds
Zinc dimethyldithiocarbamate	Salicylanilide
Pentachlorophenol	Quaternary ammonium compounds
Dihydroxydichlorodiphenylmethane	

Among these the copper compounds, the zinc compounds, salicylanilide, and certain quaternary ammonium compounds were found to be less irritant than the organic mercurials and the chlorophenols.

Washing and Dry Cleaning

Dermatitis has been caused by fabrics after they have been washed or dry-cleaned.

Underclothing and shirts washed with some of the new washing powders which may contain synthetic detergents, strong alkalis and bleaches, and which had not been sufficiently rinsed to remove them from the fabrics, have caused dermatitis.

Clothing coming from dry cleaners has also caused dermatitis. In these cases some of the high boiling solvents used in dry-cleaning solutions had not completely evaporated from the clothing and had been the actual causes of the dermatitis.

Diagnosis

Dermatitis from wearing apparel is not difficult to diagnose. The eruption begins at the place of contact with the offending material, usually five days or more after the garment has been worn. This is the period of incubation for the sensitivity to be established. The eruption may appear sooner if the person is already sensitive to the chemical in the wearing apparel which causes the dermatitis. The eruption is usually confined to the areas of the skin touched by the offending material. In exceptional cases, however, a generalized eruption may be present and sometimes systemic symptoms such as elevation of temperature may accompany the dermatitis. Positive patch tests confirm diagnosis.

The offending chemical on the fabric should be determined. In some instances it will be found to have been put on the fabric by someone other than the manufacturer, for instance, a high boiling solvent remaining in the fabric from dry cleaning, or an insecticide or an anti-mildew put on by the wearer.

Patch Test

The patch test, properly carried out and interpreted, is the most practical method for demonstrating the actual cause of a contact dermatitis. It is now also being used by manufacturers to determine the possible skin-irritating or sensitizing properties of wearing apparel containing new chemicals before placing them on sale to the public (prophetic patch tests).

The diagnostic patch test consists in applying

a small portion of the suspected substance to a site of normal skin of the patient. This is covered with innocuous impermeable material, which is then sealed to the skin by adhesive plaster. It is usually sufficient to leave the patch on for 24 hours, but sometimes when patching with low concentrations or with weak sensitizers it may be necessary to leave the patch on for three to five days, but not for more than five days, as the patient may by that time become sensitized to the patch itself. This is especially true of fabrics which contain no strong irritants and to which most people do not react. The reactions should be read not only on the removal of the patches but every day for at least three days thereafter. A later or delayed reaction indicates a lesser degree of sensitivity than an early reaction. It requires considerable experience to correctly interpret patch test reactions.

Prophetic Patch Test

The patch test for the purpose of foretelling whether a substance will or will not produce dermatitis may be called the "prophetic patch test." It was devised by me to determine possible irritant qualities of new chemicals used in the manufacture of wearing apparel, cosmetics, or other articles coming in contact with the skin. The patch test is made on 200 or more individuals using pieces of fabric about one inch square which are kept on the skin for 48 to 72 hours. Since the chemicals or compounds to be tested are new ones, it is presumed that there has been no previous contact with them.

Two series of patch tests are carried out on the same individuals 10 to 14 days apart. The first series of tests give reactions only with a primary irritant or on subjects who have been sensitized by previous contact with the chemical. The second series, performed 10 to 14 days after the first series is completed, shows the number sensitized by the first series.

Experience has shown that even one positive reaction in the second series, which did not occur in the first series, may indicate that the test substance is a sensitizer which might lead to outbreaks of dermatitis if allowed to be used by large groups.

A control patch with a substance long used for a similar purpose by the public without causing dermatitis should always be used on all the subjects. There should be no more reactions from the substance tested than from the control substance.

If no reactions of sensitivity occur in the second series or there are no more reactions from the test substance than from the control substance, then the new fabric should be made into undergarments and several thousand should be distributed for trial wear in a community of 5,000 to 10,000 for several months. Any cases of dermatitis attributed to the undergarment should be carefully investigated.

In investigating cases of dermatitis attributed to the new fabric, it must be considered that dermatitis attributed to a fabric may be caused by dry-cleaning chemicals, bleaches, strong washing powders and detergents which may remain in the fabric from laundering. Certain after-rinses used in laundering (mercuric compounds, cationics) to make the fabrics antiseptic may also cause sensitization dermatitis.

If it is definitely established that the new garment is the cause of many cases of dermatitis, the new fabric or new chemical used in processing it should not be placed on the market.

The "prophetic" patch test followed by trial usage in a small community has proved its value

in preventing dermatitis from wearing apparel and cosmetics and is now routinely used by many large manufacturers before placing their new products on the market.

Chemists are continually developing new chemicals which when applied to fabrics may add to their usefulness and appearance.

Before such chemicals are actually applied to fabrics and sold to the public, it is the duty of the manufacturer to employ recognized toxicologists and dermatologists to determine their toxic and skin irritant possibilities, and place them on sale only if they are found to be harmless.

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FAMILY DOCTORS OUTNUMBER SPECIALISTS TWO TO ONE

Nearly two out of every three physicians in private practice in this country are family doctors.

This is brought out by the American Medical Association's recent count of physicians in connection with its publication of the 18th edition of the *American Medical Directory*, according to Frank V. Cargill, Chicago, directory editor.

The new directory shows that the physicians of the United States are in the following classifications: 72,550 are in general practice and 22,976 are in general practice but give some attention to a specialty; 54,891 limit their practice to a specialty; 12,536 are in federal government service; 9700 are retired or in fields not related to medicine; 3737 are in administrative, editorial, or other executive positions related to medicine, and 24,887 are interns, resident physicians, or full-time physicians in hospitals.

The previous directory, issued in 1942, listed the number of physicians in the United States as 180,496. In the 1950 edition the number is 201,277, an increase of 20,781 and an average yearly gain of 2598 during the last eight years.

California leads in the number gained, with 16,668 physicians in 1950 as compared with 12,365 in 1942, an increase of 4303. New York state shows a gain of 2284; Texas, 772; Pennsylvania, 704; Florida, 634, and Massachusetts, 603.

Among the 24 largest cities in the United States, New York City (including Brooklyn) is first in physician population with 17,915 physicians, an increase of 1244 since 1942. Chicago is second with 7477, a gain of 294; Philadelphia is third with 4894, an increase of 649; Los Angeles is fourth with 4183, a gain of 811, and Boston is fifth with 3388, a gain of 454.

Distribution of the directory was started late in May, 1950. A new feature of the 1950 edition is the inclusion of data on the World Medical Association, covering historical material, officers and representatives, and the medical manpower of various nations.

MR. EWING VS. DR. LULL

Mr. Ewing: "Our campaign plan is to educate each of the 3000 Democratic precinct committeemen and women in all details of the National Health Insurance Plan. They will explain it to the people."

Dr. Lull: "We will have to carry on this fight until someone is licked. It is false to ourselves and false to the medical profession to take the attitude that there is no need to continue an active campaign."—*The Wisconsin Medical Journal*.

Medicolegal Aspects of the Silicosis Problem

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UPON being assigned this subject, I searched the dictionary to find a definition of the word "medicolegal" and found there was no such term in *Webster's New International Dictionary of the English Language*, second edition, unabridged. The word "medico" was defined as: (1) a physician, surgeon, or medical student; (2) a surgeonfish. When I applied the definition of the word "legal" to the definition of the word "medico," I became a bit confused as to the subject matter at hand. Therefore, if I do not cover everything you had in mind by the definition of the term, I trust you will pardon me.

The 1939 Legislature, by amendment to the Occupational Disease Law, established the method for the creation of a medical board of three members to be selected from a panel of ten, nominated by the deans of all the legally recognized medical schools in Pennsylvania. It specifically provided that the board should include a roentgenologist and a pathologist. The duty of the board was to determine, when the Workmen's Compensation Board referred a case to it for the determination of the medical facts, whether the claimant had contracted or was suffering from a disease for which he had filed a claim and whether he was disabled therefrom. A board was never appointed because of some uncertainties in this amendment to the law, such as how the members were to be paid, etc., so at the last session of the Legislature (1949) these defects were corrected, the salaries of the members were clearly provided for, and it was specifically provided that the board's reports and findings should be conclusive, except that on appeal to the courts the latter may inquire into the question whether the findings were based upon sufficient competent evidence.

The recognized importance of the physician in determining, under our law, the compensability of occupational diseases is now firmly established. Not only will doctors called by the litigants ex-

press their opinions for the guidance of the medical board but the board may appoint its own physicians to make an independent examination of a claimant and report to the board, which shall make findings of fact that will be conclusive, except, as we have indicated, the courts may review to determine whether there exists sufficient competent evidence to support the findings. Otherwise, the board might become arbitrary and capriciously disregard the testimony of record.

Since this discussion is limited to silicosis or anthracosilicosis, we want to point out, first, that Section 301 (e) of Article III of the Occupational Disease Law provides as follows:

"Compensation shall not be payable for partial disability due to silicosis, anthracosilicosis, or asbestosis. Compensation shall be payable, as otherwise provided in this act, for total disability or death caused solely (as definitely distinguished from a contributory or accelerating cause) by silicosis, anthracosilicosis, or asbestosis, or by silicosis, anthracosilicosis, or asbestosis, when accompanied by active pulmonary tuberculosis."

Therefore, it is only "total" disability or death which is compensated and only where silicosis is the "sole" cause of disability or death.

In death cases, particularly where a postmortem examination is performed, it is not so difficult to determine the cause of death and no problem arises as to the degree of disability, but only whether death was due "solely" to silicosis. It is only in the disability claims, after the cause of disability has been found to be solely that of silicosis or anthracosilicosis, that the need for the determination of the degree of disability arises. If a claimant is found to be clearly solely and totally disabled by silicosis so that he can engage in no gainful employment, no difficulty is presented. The difficult question arises for the doctors, lawyers, administrative bodies, and the courts where there is doubt about the degree of disability due solely to silicosis, that is, whether the claimant is only partially disabled or whether he is totally disabled. Likewise, if he can per-

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form light work generally, the case offers little or no difficulty, but where the ability to work borders between total disability and light work generally, a difficult problem is presented.

The Occupational Disease Law contains the same classifications of disability as the Workmen's Compensation Law, providing benefits for disability due to injuries. The law provides, first, for total disability; second, for partial disability; and third, for member losses. There have been relatively few cases in the appellate courts that define the degrees of disability under the Occupational Disease Law, but our Superior Court has said that for the purpose of determining the effect an occupational disease has on "earning power" it was guided by the decisions in the cases under the Workmen's Compensation Law involving accidents: *Jones v. The Philadelphia and Reading Coal and Iron Company*, 154 Pa. Super. 513; *Hurtuk v. Frick Coke Co.*, 157 Pa. Super. 317.

In order to determine whether the claimant is suffering from total disability, the test is not whether he is able to do exactly the same kind of work he did before the injury, but whether his earning power is entirely destroyed so that the claimant cannot obtain remunerative employment: *Byerly v. Patence Coal Company*, 105 Pa. Super. 506; *Hughes v. H. Kellogg & Sons*, 139 Pa. Super. 580.

It is not, as has been contended in a number of cases, whether the claimant can compete in the open labor market with a normal, uninjured and sound person: *Allen v. Dravo Corporation et al.*, 149 Pa. Super. 188. In this case the late President Judge Keller, speaking for the court, said:

" . . . Where the claimant has received an accidental injury which lessens his earning power but still leaves him able to do some work, neither the board nor a court has authority to extend the provisions of the Workmen's Compensation Act and award him compensation for total disability, instead of for partial disability, because, on account of his injury and consequent partial disability, he 'cannot compete in the open labor market' with normal, sound and uninjured persons. The Workmen's Compensation Act establishes no such standard and it is time that the use of this unauthorized and misleading phrase be discontinued. . . ."

Likewise, in the case of *Astudas v. General Cement Products Co. et al.*, 154 Pa. Super. 60, the court said, at page 62 of the opinion, as follows:

" . . . Even claimant's medical witness, who testified that in his opinion the claimant is now 'totally disabled,' insisted on injecting into his testimony, of

his own accord, phrases that showed he was basing his opinion as to such total disability on claimant's ability to procure employment in 'the competitive laboring market.' He said claimant was 'unemployable for competitive laboring work' and was 'totally disabled for competitive laboring work'; which, we have previously pointed out, is not the test for determining total disability in compensation cases. See *Allen v. Dravo Corp.*, 149 Pa. Superior Ct. 188, 190-191, 27 A. 2d 491. . . ."

A claimant is totally disabled when the condition resulting from a disease or an accident is such as to prevent him from doing or obtaining work for which he is mentally and physically fitted: *Winters v. State Workmen's Insurance Fund et al.*, 136 Pa. Super. 293.

In determining whether the claimant's earning power has been completely destroyed by the disease or an accident so that he is not able, because of the disease or disability, to obtain work for which he is fitted, the court said that the following factors must be taken into consideration:

1. The character and the extent of the physical injury or disability.
2. The claimant's productivity or efficiency in the same employment as compared to what it was immediately prior to the injury.
3. The ability to earn wages in any kind of employment for which the claimant is fitted.

Where a claimant is unable, because of the disease, to uninterruptedly perform even light work of a general nature, he is considered to be totally disabled: *Fegan v. Maccabees et al.*, 133 Pa. Super. 333. In that case the claimant was suffering from traumatic epilepsy. He had done a couple months' work in a relief agency where all he did was hand out jobs as the applicants came in and told them where to go, but he became so forgetful that he was finally dismissed. He suffered convulsions about twice a week and the medical evidence was that he would be a menace not only to himself but to his fellow employees. The definitions of total and partial disability are difficult of application in those cases falling in the shadow zone between partial and total disability as pointed out by the court in this case.

In *Jones v. The Philadelphia and Reading Coal and Iron Company*, supra, which we took to the Superior Court, the claimant had had a W.P.A. job and a night watchman's job and had, in spite of this fact, been awarded compensation for total disability due to silicosis. The court pointed out that during all this time he was under a doctor's care, who testified that he could

only perform selective light work and then only when "standing still" because, if he did anything requiring walking, he would quickly get out of breath. The court apparently did not consider a W.P.A. job a real job and said at page 517 of the opinion as follows:

"... when, as here, the evidence indicates that claimant performed only light work of a highly selective nature, his status as a totally disabled workman is not thereby disturbed."

The court's duty is only to determine whether the finding of total disability or partial disability is supported by substantial competent evidence. The compensation authorities are the ultimate fact-finding bodies. Therefore, it may appear as if the decisions of the courts at times are inconsistent under somewhat similar sets of facts. If there is competent evidence to support the fact-finding body's decision, that decision, which in close cases may be only a scientific guess, is final and the courts cannot upset it. That is, where the evidence is close and is contradictory, the board must make a finding and it properly uses its discretion and finds one way or the other. The court in the *Jones* case, said, at page 516, in an attempt to succinctly state the law, as follows:

"Whether the disability is total or partial is a question of fact and is for the consideration and determination of the compensation authorities': *Byerly v. Pawnee C. Co.*, 105 Pa. Superior Ct. 506, 509, 161 A. 460. 'And our review is confined to ascertaining whether or not the finding of total disability is sustained by substantial competent evidence': *Hughes v. Kellogg*, 139 Pa. Superior Ct. 580, 582, 13 A. 2d 98. Whether a claimant is totally or partially disabled depends upon the effect the injury or disease has upon his earning power: *Keiser v. Phila. & Reading C. & I. Co.*, 134 Pa. Superior Ct. 104, 4 A. 2d 188. If it appears that, because of the disease, he is not able to do light work of a general character, he is entitled to compensation for a total disability: *Consona v. R. E. Coulborn*, 104 Pa. Superior Ct. 170, 158 A. 300. The undisputed evidence here is that claimant is able to do only light work of a selective nature. He is confined to work which can be performed by him while standing still, and this limitation necessarily restricts him to work of a most selective nature."

The Superior Court, in our *Jones* case, having held that the claimant was totally and solely disabled by silicosis, awarded the claimant the maximum amount for his permanent total disability. Curiously enough, the very same *Jones*, after he was fully paid for his total disability due to silicosis, secured gainful employment and has sustained an injury to his back, and another of our

clients is paying him total disability compensation under the Workmen's Compensation Law. Hence, the physician, whose testimony the compensation authorities accepted and which was binding upon the courts, was mistaken as shown by the subsequent events.

The court, in the *Jones* case, referred to our *Keiser* case. Keiser was a tax collector in the Borough of Mahanoy City and received rather substantial emoluments of office. Tax collectors in the anthracite field are more accurately designated as tax receivers and the work incident to the office is not arduous. When we argued the case before the Superior Court, a number of the judges indicated that their position might be different if the claimant held an office, the duties of which could not be delegated, as they were in this case, to the claimant's wife. We, therefore, took up the case of *Earley v. The Philadelphia and Reading Coal and Iron Company*, 144 Pa. Super. 301. Mr. Earley had been elected a Justice of the Peace, whose duties could not be delegated. He performed the official duties and earned the fees. He operated an automobile and was able to attend and participate in "shoots" at a gun club. The Superior Court there said, "... His activities lead to the inescapable conclusion that he is not totally disabled." The court pointed out that because a claimant could not go out and compete in the so-called open labor market and do hard work because of his physical limitations it does not mean that he is an industrial "nondescript" and pointed out that that term is misleading and recommended that its use should be discontinued and said that in any instance where the court had used the word "nondescript" the claimant's incapacity was so pronounced that he was incapable of steadily doing even very light work.

There is a fundamental distinction between those who are able to do light work in general and those who are so limited in capacity that they are limited to performing special services, a class of work not generally available. The proper test is not whether the claimant is able to do exactly the same kind of work which he did before, but whether the earning power is so completely and entirely destroyed that he cannot obtain remunerative employment. The court said at page 305 of the *Keiser* opinion as follows:

"A review of our decisions will show that we have consistently adhered to the line of demarcation between the two classes of cases. The first includes persons who have sustained accidental injuries, but are capable of steadily performing certain types of

light work. It is presumed that such work is available, and that one can procure it. In those circumstances a claimant is entitled to compensation for partial disability. The second class embraces those who are not able uninterruptedly to do even light work owing to their physical limitations due to accidental injuries. If suitable work is available for such a person, it is incumbent upon the defendant to show that fact, otherwise a claimant is entitled to total disability: *Consona v. R. E. Coulborn & Co. et al.*, supra."

Hence, if a claimant is unable to perform work of a light nature or character and do it regularly or uninterruptedly, he is presumed to be totally disabled unless it can be shown that there is such work, less arduous, which is available to him and which he does or can perform. If such work is available, his earning power is not entirely destroyed so as to entitle him to compensation for total disability.

The physician must describe the claimant's physical condition as affected by the disease or injury. These facts, considered together with the claimant's physical and mental qualifications, his education and training in other work in the same or other fields of endeavor, are determinative of the claimant's ability to earn wages at remunerative employment. Earning power is not synonymous with disability. Disability and the degree of the same is purely a medical question while the extent of loss of earning power is factual and is to be determined after considering all the factors that we have enumerated pertaining to earning power. A medical opinion, to be competent and helpful on the loss in earning power, must be based on all the facts relating thereto: *Winters v. State Workmen's Insurance Fund et al.*, supra.

If a man is disabled due to disease or injury, we must determine whether he is capable of steadily performing light work or whether he is not able uninterruptedly to do even light work. If he is not, he is totally disabled and entitled to compensation for total disability.

Let us look at some of the cases. Is a man totally disabled if he can perform the job of a watchman? In *Barckhoff v. Westmoreland Coal Co.*, 161 Pa. Supra. 146, an award for total disability was affirmed although the medical testimony was to the effect that the claimant could perform the duties of a watchman if he did not have to lift, bend, or stoop. The court, in affirming the award, pointed out that since the claimant could not lift, bend, or stoop, the work he could do would be of a very selective nature and

he was, therefore, classed as a total disability case.

Likewise, in *Cox v. Woodlands Cemetery Company*, 133 Pa. Super. 313, where the claimant admitted he could act as a watchman if he could keep off his feet, the court considered that type of work to be of a selective nature. On the other hand, the court held that a claimant was not totally disabled, but only partially disabled in *Byerly v. Pawnee Coal Company*, supra, where the claimant had demonstrated his ability to act as a watchman, working every day while work was available for approximately four years and performing his work satisfactorily. Therefore, it would seem that if a claimant can do the work of a watchman without limitation, he is not totally disabled.

In *Consona v. R. E. Coulborn & Co. et al.*, 104 Pa. Super. 170, where the claimant had done some light work in a mushroom house, but had to abandon it on account of dizziness and worked only at irregular intervals, the court affirmed the award for total disability and pointed out that the claimant could do only some light work at irregular intervals and it was work of a very limited character, indicating that if he could have done his work uninterruptedly, the court might not have held that he was totally disabled.

In *Hale v. Susquehanna Collieries Co.*, 126 Pa. Super. 342, an award for total disability was affirmed where the claimant had a back injury and was unable to do any work requiring bending and could do only light work while standing. The court held that, since he could do only light work while in a standing position, this would necessarily have to be of a selective nature and the burden was imposed upon the defendant to show that such work was available.

In *Eckley v. Rae*, 128 Pa. Super. 577, where the medical testimony showed that the claimant could not do anything that required him to be on his feet, an award for total disability was affirmed. Likewise, in *Maischock v. State Workmen's Insurance Fund*, 129 Pa. Super. 118, an award for total disability was affirmed where the evidence showed that the claimant was physically unable to do anything but such light work as carrying a flag or something similar.

In *Lewis v. Bethlehem Mines Corporation*, 140 Pa. Super. 128, the court, where the medical testimony showed the claimant was disqualified for general work and could only be on his feet part of the time if permitted to rest at frequent intervals and could not lift any substantial weight

and could not stoop except with great difficulty and that any work would have to be performed leisurely with the opportunity for periods of rest, held that the claimant was totally disabled.

Where a claimant is trained only for physical work, it must be shown that the claimant is physically able to perform light work of a general character regularly without interruption. In considering a claimant's mental qualifications and training in other fields, it must be shown that the claimant has sufficient training and that he is physically able to do the things for which he is trained. In *Naughton v. Kettl*, 154 Pa. Super. 318, it was held that a claimant was totally disabled where the evidence showed that she was qualified to operate a typewriter, take shorthand, and knew something about bookkeeping and had some experience as a seamstress because the injury had so disabled her that she was only able to hobble about on crutches and, therefore, would be unable to do any of the work for which she was trained or in which she had experience.

If a claimant can do light work which is normally performed by other individuals and can perform it regularly, it is assumed that such work is available and the claimant can procure it. If he can do only a very selective type of work, it must be shown that such work is available. In the *Earley* case, an award for total disability was reversed because he performed the duties of a Justice of the Peace and was able to attend shoots at a gun club.

In the case of *Battalene v. State Work Relief Compensation Fund et al.*, 131 Pa. Super. 430, an award for total disability was reversed where the claimant admitted that he did laboring work under the W.P.A. In the case of *Beal v. State Workmen's Insurance Fund et al.*, 131 Pa. Super. 418, an award for total disability was reversed where the evidence showed that the claimant did light work in his blacksmith shop and acted as a night watchman on another job. Where a claimant admits he can do light work, he cannot be considered totally disabled, or where a claimant has demonstrated his ability to perform such work, like that of a watchman. Likewise, where a claimant worked as a bartender at a hotel, serving drinks and filling and capping bottles, lifting crocks and cases of ale without assistance, it was held that he was not totally disabled, notwithstanding medical testimony that the claimant was totally disabled: *Tomlinson v. Hazlebrook Coal Company*, 116 Pa. Super. 128.

At the trial of these cases, it is necessary, in order that the compensation authorities may make the proper findings on the degree of the loss in earning power, to show by evidence the extent and nature of the injury sustained or disease contracted, the disabled man's background and training; in short, all the information pertaining to the claimant's ability to do anything that will demonstrate an earning power. If the physician believes and can testify that the claimant can do light work generally, that would seem to end the matter. There would be no guessing left for lawyers and courts less able to correctly determine the claimant's condition and ability to work than the physician with his special training. On the other hand, if the physician does not believe and, therefore, cannot say that the claimant can do light work regularly, and by light work we mean such as that of a watchman, an elevator operator, a gas station attendant, a flagman, a bank messenger, truck spotter, or similar light work, but imposes limitations upon the claimant's ability to do all the normal duties of a watchman or any of the other types of light work mentioned, then we get into difficulty and we have to show that the work which the claimant can do, with the limitations mentioned by the physician, is available to the claimant.

It is a very simple matter if the doctor can say that the claimant is totally disabled or can do light work of a general character, but an opinion that places the claimant in a status between total disability and ability to do light work generally results in placing the ultimate decision in the hands of those probably much less qualified to determine whether the claimant is totally disabled or partially disabled than the physician. It must be remembered that a decision has to be made in each case. It is more helpful to the compensation authorities if the doctor can and is willing to express a clear-cut and unequivocal opinion.

In conclusion, let us state that it is almost impossible to lay down a yardstick that will permit us to determine in each instance whether an injured or diseased person falls into the class of those able to do light work generally or those able to perform merely selective light work. Each case depends upon its own facts. The duty of the lawyer is to present all the relevant facts as clearly as possible. In the presentation of those facts, the opinion of the physician is most important both as to the extent of disability and

the impairment of earning power. Lawyers should attempt to explain the law to the witness so that he understands clearly the legal effect of his language that he intends to use in describing the physical condition of the claimant. It has happened and we regret that it will happen again that the legal effect of the words used by the physician is totally different from what he actually intended. He may believe that the claimant is far from totally disabled and has a substantial earning power, but his limitations on the character of work that he may say the claimant can perform will definitely place the claimant in the class of totally disabled persons without any earning power whatsoever.

When the new medical board is appointed, we

hope that it will so clarify its findings of fact that there will be no question about the degree of disability and the extent of impairment of earning power and, therefore, the classification into which the claimant falls under the Occupational Disease Law. Only by clear thinking and accurate determination of the facts can confusion on this subject be eliminated or materially minimized.

I am appreciative of the opportunity to appear before you and to indicate some of the problems that confront us, as physicians and lawyers, under the Occupational Disease Law of this Commonwealth and which may be included within the subject, "Medicolegal Aspects of the Silicosis Problem."

STATE SOCIALISM AND WELFARE STATE SYNONYMOUS

The Chicago Bar Association, through its Committee on Federal Legislation, has soundly denounced all pending proposals for socialized medicine. We quote one or two significant passages from this report:

"It has been said that the tide of governmental management is resistless, that one may as well become reconciled to the fact of ever-increasing authoritarian regulation."

"*That sentiment* is the very beginning of the winning fight against socialized medicine" states Congressman L. C. Arends from the 17th District, Illinois. "The American people must take a stand, not against one item in the socialist program, nor yet against two items. We must take a stand on principle against state socialism—and be prepared to fight any and every proposal which heads in that direction!"

"Let me remind you that socialized medicine is not a program designed to care for the needy and the underprivileged. On this point the report of the Chicago Bar Association was clear and emphatic beyond misunderstanding."

What that report proposes is to establish government control of the medical care of every man, woman, and child in the United States, including all who are amply able to provide all necessary care for themselves and their dependents and are doing so at the present time.

"So this is not a program for the needy," continues Congressman Arends, "it is a greedy grasp for power by the Washington bureaucrats."

"This is somewhat of a challenge to each and every doctor to devote some of his time, effort, and money in support of individuals who hold the same belief in government principles that the doctor or small business man does. In no other way are we going to be able to save our present form of government. Such is my honest opinion. It is your job just as much as it is mine."

"If you are going to leave the matter of politics up to what is commonly known as 'politicians,' then you are entitled to get just what politicians give you."

"Doctors are among the most influential individuals in community life. Do you have the courage to face this challenge? I am willing to do my best. These socialistic plans must be knocked off, one after another, if we are to remain a nation of free people."—*Illinois Medical Journal*.

BLUE SHIELD PLANS PAY 80 MILLIONS TO DOCTORS

Payments to doctors of nearly 80 million dollars in 1949 were made by 61 of the 68 Blue Shield plans of voluntary, prepaid medical care operating in 40 states, Hawaii, Puerto Rico, and Canada, according to the year-end report of Associated Medical Care Plans, national association of Blue Shield plans.

The Medical Service Association of Pennsylvania paid nearly three million dollars of the total for professional services provided to Blue Shield members in the Keystone State.

The more than 14,000,000 Americans enrolled in the 68 plans at the end of last year paid \$100,283,202 for their health security, of which slightly more than one twenty-fifth was received by MSAP as income.

Reservices of \$3.02 per subscriber were reported by MSAP, the second highest among the six largest plans. Nationally, the Blue Shield plans had reserves of \$1.76 per member. The Pennsylvania Plan was one of eight among the 61 reporting which increased its assets by 100 per cent or more during 1949.

Almost 10 per cent of the total population of the 40 states and the District of Columbia in which Blue Shield plans operate held this type of health care protection. Here in Pennsylvania, only 5.24 of the population was covered, according to the AMCP reports.

The Second Five-Year Report on Poliomyelitis in Allegheny County 1945-1949 Inclusive

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THIS IS the second report covering a five-year period of acute cases of poliomyelitis in Allegheny County. It is for 1945 to 1949 inclusive. The first report was published in the September, 1945 issue of this JOURNAL.

These reports are based on information collected at the onset of each case by the field worker of the Allegheny County Chapter of the National Foundation for Infantile Paralysis. They are made possible by the cooperation of the city and county health departments with the Chapter. This is a method of case finding that brings each case to the attention of the Chapter at its very beginning so that its services are available at the earliest possible moment. For some years it has been the policy in Allegheny County to encourage early hospitalization. Special equipment and services, for the most part, are available only in specially equipped institutions.

The total number of cases covered by this report is 242. There were 16 deaths, but two of these were of patients who had contracted the disease respectively nine and four years previously.

Multiple infection (two or more cases in a family) occurred in five instances with a two-day interval in two cases, a three-day period in one, a four-day interval in one, and a five-day interval in the remaining one.

Most of the facts are presented in tabular form for the sake of brevity.

Not only does this report show a greater number of cases than the first but it also shows a reversal of the relative incidence between the city and county, that is, it shows a greater number of cases in the county outside Pittsburgh. There

AGE OF PATIENTS

Age	Cases	Age	Cases
Under 1 year	2	16 years	5
1 year	16	17 years	6
2 years	24	18 years	1
3 years	17	22 years	1
4 years	14	23 years	6
5 years	20	24 years	3
6 years	19	25 years	1
7 years	13	26 years	3
8 years	8	27 years	2
9 years	17	28 years	2
10 years	10	29 years	1
11 years	15	30 years	2
12 years	12	34 years	1
13 years	6	35 years	1
14 years	9	37 years	1
15 years	4		

Race	Cases	Sex	Cases
White	234	Males	150
Colored	8	Females	92

NUMBER OF CASES BY YEARS (1940-1944)

Year	City Cases	County Cases	Total
1940	2	6	8
1941	14	10	24
1942	3	3	6
1943	0	4	4
1944	82	50	132
	101	73	174

NUMBER OF CASES BY YEARS (1945-1949)

Year	City Cases	County Cases	Total
1945	34	39	73
1946	12	18	30
1947	16	19	35
1948	16	17	33
1949	31	39	70
	109	132	241

Dr. Robinson is chairman of the Allegheny County Medical Society Committee on Poliomyelitis.

The expense incident to the collection of data for the preparation of this report was met by the Allegheny County Chapter of the National Foundation for Infantile Paralysis.

were only 9 more cases in the city, while there were 58 more cases in the county outside the city.

Onset and Distribution of Cases: In 1945 the first case appeared in the 30th ward of the city; in 1946, in Etna; in 1947, in Ohio Township; in 1948, in Coraopolis, and in 1949 in McKeesport.

DISTRIBUTION OF CASES IN THE CITY

Wards	No. of Cases	Wards	No. of Cases	Wards	No. of Cases
1	1	12	5	23	1
2	0	13	7	24	0
3	2	14	13	25	4
4	5	15	8	26	1
5	3	16	3	27	5
6	2	17	3	28	1
7	1	18	3	29	3
8	2	19	12	30	3
9	3	20	2	31	2
10	8	21	1	32	1
11	3	22	2		

DISTRIBUTION OF CASES IN COUNTY OUTSIDE
PITTSBURGH

Subdivision	No. of Cases	Subdivision	No. of Cases
Aleppo Twp.	1	Mt. Lebanon	6
Aspinwall	2	Mt. Oliver Boro ..	2
Avalon	1	McKees Rocks ...	2
Bellevue	1	McKeesport	7
Brentwood	2	McCandless Twp. .	3
Ben Avon	1	Natrona	1
Braddock	1	N. Versailles Twp.	2
Baldwin Twp. ...	1	N. Braddock	1
Berdonner	1	Ohio Twp.	1
Carnegie	3	Pine Twp.	1
Clairton	2	Penn Twp.	2
Coraopolis	2	Port Vue	1
Curtisville	1	Plum Twp.	1
Crafton	1	Rankin	1
Dormont	4	Rosedale	1
Duquesne	3	Ross Twp.	2
Dravosburg	1	Springdale	3
Etna	1	Sewickley	5
Edgewood	6	Swissvale	1
E. Pittsburgh ...	1	Shaler Twp.	1
Elizabeth	1	Stowe Twp.	1
Frazier Twp.	1	Tarentum	2
Glenshaw	3	Turtle Creek	3
Hampton Twp. ...	2	West Homestead .	1
Homestead	2	Wilkins Twp.	1
Ingomar	1	West Mifflin Twp.	2
Ingram	2	Wexford	3
Jefferson Twp. ...	2	West Deer Twp. .	3
Kenmawr	1	West View	4
Liberty	1	Wilkinsburg	5
Moon Twp.	2	Willock	3
Millvale	5	Versailles Twp. ..	1

Drainage, Water and Milk Supply: Nothing significant appears under this heading. Two hundred and ten homes were connected with sewers. Nineteen had septic tanks, and 7 had privies. As to the water supply, 222 homes received water from the city supply or by an authentic water authority, 15 from deep wells, and 5 from springs. Only four families used unpasteurized milk.

Animals in or About Patients' Residences: In only 27 cases were "no animals" reported. There were dogs in the homes of 173 patients and, of course, all other domestic animals were recorded, but in much smaller numbers.

Insects Reported in Homes of Patients: In 25 cases "no insects" in the homes were reported. In 213 cases "flies" were reported, and in 120 cases mosquitoes were reported. All the other common insects were present, but in relatively small numbers.

Trips Outside Allegheny County: This record is kept so that any source of infection outside the county can be noted promptly. As far as we could tell, there was only one case (from Chicago) that might have been brought from outside the county, that is, in which the original infection occurred outside the county.

Picnics: This record is kept so that any particular source of infection in picnic places can be noted promptly. There was nothing significant.

Swimming: For the most part the patients who gave a history of having been swimming did so in approved pools. There were several who swam in the ocean or Lake Erie, but the time, as far as the period of incubation was concerned, would make negligible the possibility of their having picked up the infection at that time.

TIME INTERVAL BETWEEN ONSET OF INITIAL
SYMPTOMS AND APPEARANCE OF
PARALYSIS

Days	Cases	Days	Cases	Days	Cases
1	37	9	1	17	0
2	56	10	1	18	0
3	47	11	1	19	0
4	30	12	0	20	0
5	20	13	1	21	1
6	16	14	2	23	1
7	8	15	1	32	1
8	4	16	1	Unknown	13
	218		8		16

Figures in this table are approximate.

ONSET DATE OF THE DISEASE

Month	1945	1946	1947	1948	1949	Total
January	0	0	0	1	0	1
February	0	1	0	0	0	1
March	0	1	0	0	0	1
April	0	0	0	1	0	1
May	1	0	0	1	3	5
June	1	1	2	2	1	7
July	5	0	2	5	7	19
August	20	8	9	6	32	75
September	24	6	16	10	15	71
October	18	11	5	3	8	45
November	4	2	1	3	2	12
December	0	0	0	0	4	4

(This is the first time in our ten-year study that cases have appeared in all months of the year.)

Symptoms: The following symptoms are only those which were reported to the field worker and represent only those present in the early days of the first or acute stage of the disease.

Bowel condition—constipation present in 115 cases; diarrhea in 7 cases; bowels normal in 120 cases.

Vomiting—present in 149 cases; absent in 93 cases.

Headache—present in 178 cases; absent in 64 cases.

Fever—present in 228 cases; absent in 14 cases.

Reflexes insofar as noted—increased in 42 cases; decreased in 117 cases; normal in 83 cases.

Nuchal rigidity—present in 207 cases; not present in 35 cases.

Sore throat—present in 92 cases; absent in 150 cases.

4 cases; abdomen only, 5 cases; back only, 10 cases. In all other cases (99) the pain was present in two or more locations.

Mental State: Restlessness was present in 116 cases; drowsiness in 50 cases; stupor in 1 case; restlessness with drowsiness in 3 cases; restlessness with stupor in 2 cases; restlessness with drowsiness and stupor in 14 cases; drowsiness with stupor in 1 case; normal in 55 cases.

DIAGNOSIS AT ONSET OF DISEASE

	Cases
Spinal pre-paralytic	1
Abortive	6
Spinal	186
Bulbar	18
Bulbospinal	19
Poliomyelitis (ascending)	1
Poliomeningo-encephalitis	3
Poliomyelo-encephalitis	4
Polio-encephalitis	2
Encephalitis	2

Muscle Spasm in Extremities: This was noted in so few cases at the beginning as to be unworthy of reporting.

Location of Paralysis: In 25 cases there was no paralysis; 43 cases had paralysis of both legs only; right leg only, 32 cases; left leg only, 28 cases; both arms only, 4 cases; right arm only, 5 cases; left arm only, 8 cases; neck only, 2 cases; chest only, 2 cases; pharynx only, 1 case; throat only, 15 cases; face only, 4 cases; back only, 2 cases. In all other cases the paralysis was of two or more different groups of muscles. It must be remembered that these figures are only those which were reported at onset.

Tonsillectomies: Ninety-five patients had their tonsils removed prior to 1949; 145 patients did not. Two patients had tonsillectomies within two months of onset. Both of these were of the spinal type.

DAYS AFTER ONSET WHEN PATIENT WAS ADMITTED TO HOSPITAL

Days	Total	Days	Total	Days	Total
1st	23	9th	7	17th	0
2d	30	10th	6	18th	2
3d	39	11th	4	19th	1
4th	37	12th	3	20th	0
5th	26	13th	5	21st	1
6th	12	14th	1	22d	0
7th	15	15th	2	23d	1
8th	9	16th	1	Unknown	4

(Thirteen cases were treated at home.)

History of injury:—only one patient gave a history of injury within the incubation stage. This man had had a head injury, but all consultants verified the diagnosis of poliomyelitis.

Location of Pain: There was no pain present in 42 cases; neck only, 25 cases; both legs only, 25 cases; right leg only, 13 cases; left leg only, 8 cases; right arm only, 1 case; left arm only,

Conclusion

The report shows a moderate increase in the number of cases of poliomyelitis in Allegheny County. This increase was greatest in the area outside the city limits of Pittsburgh. We do not

know the reason for this. It would be presumptuous to publish definite conclusions on how our polio patients in Allegheny County were infected, whether through contact or by an insect vector or other means. Nevertheless, there is a challenge involved which should not be ignored.

BLUE SHIELD NON-GROUP ENROLLMENT INCREASING

In the eight months since non-group enrollment in the Blue Shield voluntary, prepaid medical care plan was first offered to the public in Pennsylvania, nearly 35,000 subscribers have joined on this basis.

Non-group enrollment is available in all counties of the State, except Lehigh and Northampton. Negotiations are being conducted at the present time with officials of the Hospital Service Plan of the Lehigh Valley, which acts as the enrollment agency for Medical Service Association of Pennsylvania in Lehigh and Northampton counties, to make non-group enrollment available there also.

Any person who is under 66 years of age and in good health may enroll in Blue Shield on a non-group basis. All of the benefits available under group enrollment also are provided to subscribers who enroll on a non-group basis, except that payment for home and office calls is not included in the Non-Group Medical-Surgical Agreement.

MAJORITY OF FATALITIES FROM HEART DISEASE ATTRIBUTED TO FIVE DISORDERS

Although medical science has classified more than 20 types of heart disease as capable of causing death, only five account for the majority of fatalities, according to an article by Dr. C. J. Van Slyke, director of the National Heart Institute, appearing in the current issue of the *Practical Pharmacy Edition of the Journal of the American Pharmaceutical Association*.

The five most fatal types are congenital malformation, rheumatic heart disease, syphilitic heart disease, hypertension, and coronary arteriosclerosis.

"Congenital malformation, due to the failure of the heart to develop during the prenatal period, and rheumatic heart disease, a condition frequently left in the wake of rheumatic fever, are the two heart conditions encountered in childhood," Dr. Van Slyke said.

"Syphilitic heart disease, while appearing most often in middle age, is usually a late result of syphilitic infection contracted in early adult life," the noted heart authority continued.

Dr. Van Slyke pointed out that "the remaining two heart conditions of outstanding importance are hyper-

tension, where prolonged high blood pressure of an unknown origin has affected the heart, and coronary arteriosclerosis, a hardening of the nutrient arteries supplying the heart."

Stressing the ever-growing seriousness of the problem of heart disease, Dr. Van Slyke said, "The scope of the heart problem is one of ever-increasing magnitude, embracing a larger segment of our population with each passing year. The importance of this problem should be of concern to every thoughtful citizen. It is of particular concern to the pharmacist, who is a most important guardian of public health."

To focus greater attention on the need for preventive and remedial measures, neighborhood pharmacies throughout the country will join in an effort to warn the public of the dangers of heart disease and to urge everyone exhibiting any of the symptoms to see his physician for an immediate physical checkup.

DO YOU OR DON'T YOU?

1. —Do you want to be a political servant?
2. —Do you want to make house calls carrying a brief case instead of a grip?
3. —Do you want your patients to demand treatment, special diets, and other remedies even though they do not need them?
4. —Do you want to spend half your time arguing with patients as to the advisability of renewing a disability certificate?
5. —Do you want to practice medicine without being thanked?
6. —Do you want to be forced to spend so much time with neurotics that you cannot treat those who are in dire need of care?
7. —Do you want to be so rushed that you are forced to practice second-class medicine?
8. —Do you want to consult an eight-hundred page looseleaf book each day to familiarize yourself with all the changes in regulations in medical care which the Government has deemed necessary?
9. —Do you want to lower your standard of living?

If not, cooperate with your medical society by paying the extra assessment and campaign against socialized medicine in your local community.—*Illinois Medical Journal*, October, 1949.

Mammoplasty Procedures in the Female

HANS MAY, M.D.

Philadelphia, Pa.

BREASTS are deformed according to the esthetic appearance of females either because they are markedly enlarged, inconveniencing the patient on account of size and weight, or because they are pendulous, sac-like, with or without hypertrophy of the dependent glandular portion.

A variety of operations have been devised for reconstruction of breast deformities. Some are performed in one stage, others in two stages. I have given a number of these methods a fair trial and have also devised a method of my own. Experience, however, has taught me that none of the various procedures can safely be applied to every single type of breast deformity.

I have now worked out a combination of certain useful features of some of the standard methods, such as Lexer and Biesenberger, and apply this procedure to reconstruction of medium and fairly large sized pendulous breasts. This method preserves the nipples and function of the gland and can be performed in one stage. Although technically it is applicable for correction of all degrees of breast hypertrophy, it is not advisable to apply this procedure in markedly hypertrophic breasts since it, like any one-stage procedure that is intended to preserve the function of the gland, endangers the blood supply to the nipple. The blood supply of the breast is derived from three sources: branches of the arteria axillaris, of the mamma interna, and arteria intercostales. The third and fourth branches of the arteria mamma interna carry the main blood supply not only to the gland but also to the areola. The branches of the arteria axillaris supply only the lateral superficial parts of the breast; the intercostal arteries are insignificant. Hence, the areola receives its blood supply from beneath—from branches of the arteria mamma interna—and also from the surrounding skin. If the areola is separated from the surrounding skin but left attached to its base, a sufficient blood

supply is guaranteed from beneath. If, however, in addition to skin incisions much breast tissue needs to be removed, the deep blood supply of the areola may become insufficient. Hence, in markedly hypertrophic breasts requiring much reduction, I advise a plastic amputation of the breast with free transplantation of the nipples (Thorek) rather than a procedure which endeavors to preserve the nipples and the function of the gland. This operation can be performed in one stage. The cosmetic appearance after the reconstruction is most satisfactory. The fear that this operation may lead to cystic degeneration or other pathologic changes (malignancy, etc.) of the breast is unfounded, particularly so since most of these large breasts have little if any glandular tissue. If a woman after such an oper-

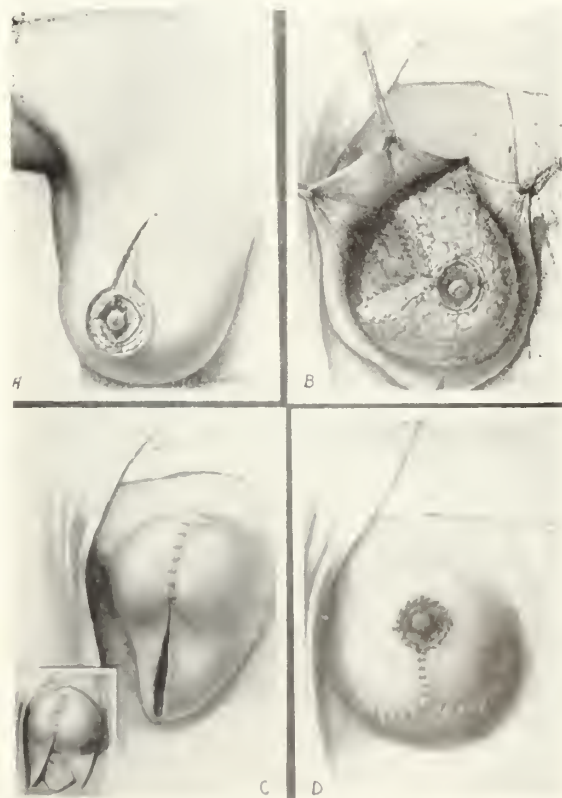


Fig 1. Breast plasty with preservation of the function of the gland.

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.



Fig. 2. Breast plasty consisting of partial amputation of the breast with free transplantation of the areola.

ation becomes pregnant—as has happened in three of my patients—the function of the gland can be promptly stopped by the administration of stilbestrol.

The patient is operated upon in a half-sitting position under general anesthesia. The operation for correction of medium and fairly large sized pendulous breasts, with preservation of the nipples and function of the gland, is performed as shown in Fig. 1. The new site of both nipples is selected and marked with a drop of methylene blue injected intracutaneously. An incision is made around the areola. A vertical incision is made from the new site of the nipple to the upper pole of the areolar incision, and continued from the lower pole two-thirds of the distance between the nipple and mammary fold. The skin and a thin layer of subcutaneous fat tissue is now dissected away from the breast, mostly by blunt stripping, until the whole body of the breast is developed. A wedge-shaped piece of tissue is removed from the upper and lower lateral quadrants. The wound edges of the breast tissue are approximated with a few sutures. The skin is then draped around the breast like a brassiere. The skin edges are excised accordingly and the wound is closed. Thus the nipple becomes temporarily buried beneath the skin. The same procedure is now performed on the other side. The final step is the excision of skin over the buried areola and the adjustment of the areola to the

wound edges. The proper position of the skin to be excised is visually rechecked and the incision is marked out with one of the dyes. It should have the same width as the buried areola, hence it is advisable to use a certain standard pattern for the original incision around the areola, as well as for the one at the new site. The marked out skin is now excised and the areola is drawn out and sutured to the wound edges. A drain is inserted into each lateral wound corner and a



Fig. 3. Patient, 20 years of age, with pendulous breasts. Breast plasty performed with preservation of function of the gland.

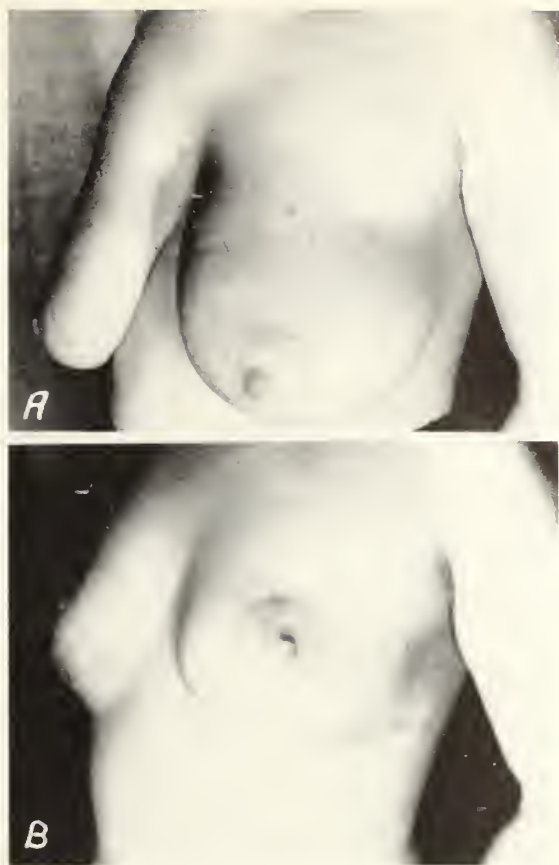


Fig. 4. Patient, 42 years of age, with hypertrophic pendulous breasts. Breast plasty performed with preservation of function of the gland.

heavily padded pressure dressing is applied. The drains are removed after three days; the sutures are removed one week after the operation (Fig. 3).

The technique of plastic amputation of markedly hypertrophic breasts with free transplantation of the nipples is performed as shown in Fig. 4. First, the areola is removed as a free graft. No subcutaneous fat tissue should be left attached to the nipple. The areola is carefully wrapped in gauze wet with saline solution. The graft wrapped in the gauze is clamped to the covers of the instrument table with two towel clamps as a precaution against them being discarded. An anterior semicircular incision is made. A line connecting the extremities of the incision should be on the level with the mammary fold on the posterior side of the breast. The breast is now elevated and an incision is made on the posterior side parallel to and about one inch above the mammary fold. The skin edges are undermined along the anterior and posterior incision; the redundant mammary tissue is now excised with an ordinary amputation

knife, and the remainder is shaped and inverted with heavy catgut sutures. The two skin flaps are trimmed to fit snugly over the reshaped mammary tissue and united with a row of subcutaneous and skin sutures. A drain is placed in the lateral wound corner.

The new site to which the areolae are to be transplanted is visually selected and marked out with one of the aniline dyes. The same pattern technique is used as described above. The skin of this circular host area is dissected away as with a thick split graft, leaving a thin basal layer of derma behind. The subcutaneous fat tissue should not be exposed since adipose tissue is not as well vascularized as the derma of the skin. The previously excised areola is transfixated with a straight needle and carefully sutured in place with a continuous suture of fine nylon or silk on an atraumatic needle. The same procedure is performed on the other side. A firm pressure dressing is applied over the transplanted areola and held in place with adhesive plaster. Upon this dressing another heavily padded pressure dressing is applied to the breast. The pressure dressing over the graft should not be changed for at least ten days, while the other part of the

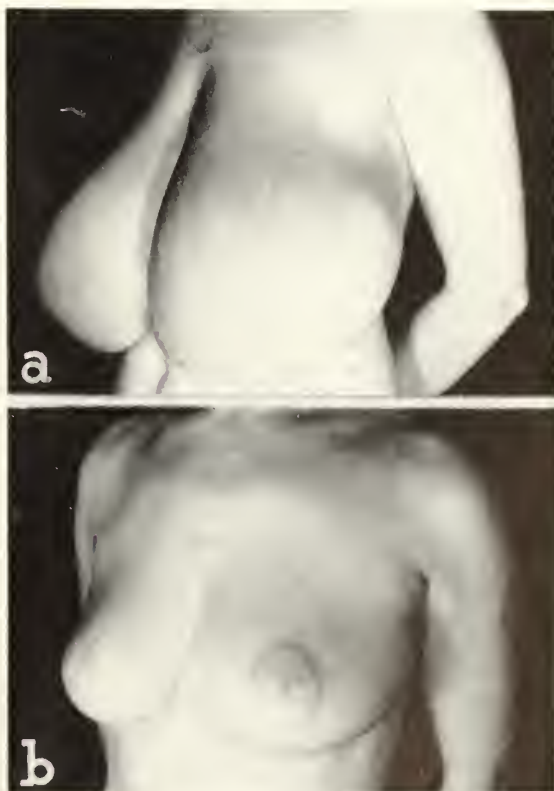


Fig. 5. Patient, 27 years of age, with marked hypertrophy of the breasts. Deformity was repaired by partial amputation of the breasts and transplantation of the nipple as a free graft. Seven months after operation.

dressings is changed and the drains are removed on the third day (Fig. 5).

Summary

Reconstruction operations for correction of various forms of hypertrophic breasts are described and illustrated. A one-stage procedure with preservation of the function of the gland is chosen for reconstruction of medium-sized pendulous hypertrophic breasts. Plastic amputation

with free transplantation of the nipple is the procedure of choice for markedly hypertrophic breasts.

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THE BLIGHT

We have recently noted with considerable interest a review by Clarence A. Mills, professor of experimental medicine, College of Medicine, University of Cincinnati, of the preliminary report of a year-long study by the Public Health Service of the Donora tragedy.* Twenty persons lost their lives in Donora in America's first known mass killing from industrial air pollution. As Dr. Mills states, "This represents the U. S. Public Health Service's first foray into the field of community air pollution. Two years ago they were not even interested in making a small grant to help studies already well along in opening up this health field. Today they suddenly find the field so important that they quickly request \$750,000 from Congress to enlarge upon their studies. Just what did their year's work, with a staff of 25 investigators, show?"

It would seem the U.S.P.H.S. confirmed the private investigations made immediately after the disaster at the request of the citizens of Donora, that they overlooked the significance of their extensive testing throughout the following year together with the effects of the fumes on domestic animals and plant life. Needless to say, the Federal Security Administrator and the Surgeon General did not neglect to claim that they had opened a new field in the nation's health, blandly ignoring the prior years of work of others.

The incident may be rather characteristic of what Mr. Ewing has done to the Public Health Service. One questions the propriety of his intrusion into a scientific report of the Service. And then one realizes the ever-growing emphasis in printed material and publicity releases on the "Federal Security Agency." Perhaps Mr. Ewing intends to make personal capital out of the work of the Service. The medical profession has long respected the United States Public Health Service, having in remembrance the many distinguished investigators who served it in the past, and certain outstanding surgeons general. It will be regretted if Mr. Ewing succeeds in bending the Service to his personal ambitions, if its direction falls into the hands of men without personal knowledge of the problems and disciplines that are involved.

One may already hear many stories of the growth of

the power of the administrator in the health services. What should come first seems often second to an administrative machine without insight or the necessary knowledge. Indeed, one would like to know what prompted Dr. Parran's resignation and whether at that time, Mr. Ewing's power being confirmed by the President, the U. S. Public Health Service, as doctors knew it, was mortally wounded. Under the new formula may the expenditures be expected to become larger and larger and the results more and more trivial? The F.S.A. public relations men may give the accomplishments an air of importance and no doubt will credit them to their boss, but the Service itself is likely to be as badly blighted as Donora.—*New York State Journal of Medicine*.

TWO DON'TS AND TWO DO'S

On the medical sector of the total war against predatory bureaucracy, experience has proved that the medical profession must observe two don'ts and two do's in order to battle more effectively.

Don't attempt to be theoretical, philosophical, or hypothetical in your presentation of our cause. You will be defeated because, on paper, compulsory sickness insurance is simply perfect and perfectly simple.

Don't ask consideration for the art of medicine, for the science of medicine, for the traditions of medicine, for the status of doctors nor of the doctor's pocketbook. If you do, you will be accused of having "a vested interest in the status quo," and in this day, when communistic propaganda dominates the thinking of so many people in all parts of the world, having any vested interest and favoring any status quo are about the worst sins you can commit!

Do rely on historical fact, human experience, and the words of the various editions of the Wagner-Murray-Dingell bills themselves. Facts outfight fiction.

Do you remember that you are dedicated to the best interests of the patient. Base every argument upon whatever is in the best interests of the patient. Your only excuse for being in this battle is that you are fighting for those interests of the patient.—*Rocky Mountain Medical Journal*, March, 1950.

* *Science*, 3: 67 (1950).

Undergraduate Teaching of Public Health and Preventive Medicine in a Medical School

PASCAL F. LUCCHESI, M.D., and CHARLES L. BROWN, M.D.

Philadelphia, Pa.

WHEN George Washington had his false teeth made, a silversmith by the name of Paul Revere was called upon to fashion them. This man is better known to you for a certain jaunt on horseback on a certain night in 1775 (which some historians insist that he didn't even take), but perhaps most of you didn't know that he was the first chairman of Boston's Health Department. When Paul Revere, that jack-of-all-trades, directed Boston's small public health outfit, the common concept was that the duty of a health department in the field of preventive medicine was only to prevent something which was undesirable in the way of filth, such as an overfull cesspool or the deposition of chicken heads on the lot of a neighbor.

Somehow we wonder if some of our medical schools are still teaching that concept alone, in reference to public health and preventive medicine. The concept of filth as the source of illness was very good in its day, and is still an acceptable one, but that is not all there is to the teaching of preventive medicine and public health. Although we cannot say that the absolute control of filth is as yet an accomplished fact, and that we should drop any mention of it in our teaching of preventive medicine, as the "advanced thinkers" demand that we should, the medical profession has advanced much farther than that concept, and medical schools should change with it.

As medical science advanced through the eighteenth and nineteenth centuries, another concept in the field of public health and preventive medicine adopted was that of the control of communicable diseases. The posting of isolation and quarantine signs on doors of homes where communicable disease existed and the tracing of ex-

posed persons was prosecuted vigorously, and the budding physician was taught that this was the thing to do. No one can deny that such procedures are still a part of public health and preventive medicine, and should still be taught in medical schools, but that is not *all* to preventive medicine.

Another concept in public health adopted in the past century is that such a department of the government keep a record system of the rise and fall of the population—a "family bible," as it were, of the community, noting the births and deaths in this large "family"—who among them was sick and with what disease and what he died from and when. Biostatistics and the teaching of the legal responsibilities of a physician in the reporting of births, deaths, and certain diseases became a part of the curriculum of the medical school and bids well to continue to be such. But teaching a prospective physician, for instance, that if he uses a ball-point pen in signing a certificate of death he is breaking the law does not in any way discharge the responsibilities of his preceptors in teaching him public health and preventive medicine.

This brings us to the main topic of our discussion. What things are there "new" in preventive medicine and public health which we have not been teaching adequately in our medical schools up to now, which we have not stressed sufficiently but which demand that the neoteric physician leaving our medical school should be taught? The first of these is the problem of our aging population. The fight against infectious diseases in childhood is going very well. A child at the age of 11 today stands the least chance of dying of any of us during that year. An infant born at the Battle of Germantown had a normal life expectancy of 35 years. A child born today may be expected to live to be 67 to 69 years. While the lengthening of the span of life has been a most

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From the Department of Public Health and Preventive Medicine, Hahnemann Medical College and Hospital, Philadelphia.

desirable achievement (for which public health and preventive medicine may well take a large share of the credit), it has nevertheless created other problems which promise to be of serious socio-economic import to our country. The emphasis is shifting from the young to the old—from communicable to degenerative diseases. Whereas in 1900 tuberculosis, pneumonia, and enteritis were the first three leading causes of death, today diseases of the heart, cancer, and accidents are far in the lead over any infectious disease as the cause of death.

The important community changes which took place in the past half-century—the aging of the population, the industrialization of the country, and the urbanization of the population—have likewise brought about similar reactions in medicine. Men who see a real cross-section of the community in a large general hospital can assure you that the problem of the aged and chronically ill is already with us—a problem far more important economically and socially than any recorded epidemic of communicable disease. We have some figures from the Philadelphia General Hospital, where a recent study (March, 1949) on a certain day showed that the mean age of a patient on that day was 46 years, and that 60 per cent of the patients were over 40 years of age.

The second problem which has arisen in public health and preventive medicine is that physicians have not adequately been made aware of the vast amount of auxiliary services to the medical profession which have arisen in the past 50 years. There are few among you who graduated 15 years ago who had any idea that visiting nurse societies, family welfare societies, the medical services of the various boards of education and of our courts even existed. The community resources other than hospitals available to a physician concerned with the total health of his patient are fabulous, yet it takes years for most of us to learn about them, and the hard way, to boot.

The above two problems are intimately related. Many of you spend hours trying to locate a hospital bed for an aged person who has had a fractured hip, or a cerebral hemorrhage, or who has become a harmless senile vegetable, because the family cannot take care of him at home or is unwilling to do so. Yet there are many community agencies, both official and voluntary, who could assist you if you only knew how to go about it.

The physician of today, then, must be so edu-

cated that he will not only become skilled in diagnosis and treatment in the way of drugs and physical and psychologic medicine but also in the social sciences. He should again become the family confidant as he was in the past—one who solved their troubles not only with pills and salves but who called in the neighbors to help. With the shift to the diseases of the aged, then, our emphasis on the training of physicians of tomorrow must not be confined to the conventional form of teaching—etiology, pathology, diagnosis, therapy, prognosis, and a smattering of prevention as an afterthought.

The student must be made conscious of the patient as a total individual—a part of the community. He should be made to regard the patient as having a mind as well as a body—as one just as interested in what will happen to his family as he is in the outcome of the ulceration of his stomach.

He must himself be so aware of his environment and the public health resources that he can make them available to his patient. He must be as conscious socially as he is clinically. If we impress a student with these responsibilities, we will then have a doctor who will not prescribe a diet his patient cannot buy, a rest or vacation he cannot afford, a return to a clinic when he lacks the carfare, or the isolation of a patient with communicable disease in an overcrowded home.

This type of teaching has become known as "socio-economic medicine." The American Medical Association reaffirmed this year its interest in the social welfare of every American, so let us not confuse "socio-economic medicine" with what has become known as "socialized medicine." It is not an attempt to focus on medicine the blame for all the social and economic ills of the nation, as is being urged by those who would have you believe that this country has never been so ill-fed, so ill-housed, and in such ill health as now. It is rather an attempt to teach the physician that through his efforts he can obtain assistance for his patients by utilizing health and welfare agencies already available; thus, contributory troubles which are inimicable to the total health of his patient can be removed, and a more rapid recovery of his illness be accomplished.

These modern and broad concepts of the medicine of today must be presented to the student in all of his clinical subjects, for every disease will have its own peculiar social problem. The social problems caused by diabetes are different from

LECTURE SCHEDULE ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

(Second Year)

First Quarter

- Introduction to course
- History of public health development in the United States
- Organization of state and municipal county health departments
- Public health services furnished by municipal and county health departments to public
- Organization of national health agencies
- Public health services furnished by national health agencies
- Voluntary health agencies and services available to public
- Basic principles of communicable disease control
- Specific services of local health departments
 - (a) Public health education

Second Quarter

Specific services of local health departments

- (b) Public health laboratory services
- (c) Public health nursing
- (d) Maternal and child health services
- (e) Meat, milk, food, drugs
- (f) Environmental sanitation

Health services of other official agencies

- (a) Medical services of the Board of Education
- (b) Municipal court and county prisons
- (c) Department of Public Welfare
- (d) Department of Public Assistance
- "Services of Department of Public Assistance"

Third Quarter

Health services of unofficial health agencies

- (a) Hospital council (organization and purpose)
- (b) State Health Council
- Health and Welfare Council
- (c) Voluntary insurance plans
- Blue Cross-Blue Shield
- (d) Medical social work

Public health administration

- (a) Public health administration in Philadelphia
- (b) Visit to Department of Public Health
- (c) Visit to consolidated health center—Starr Center
- (d) Function of health center

Environmental sanitation

- (a) Introduction
- Water purification
- Sewage disposal
- (b) Refuse
- (c) Air pollution
- (d) Housing
- (e) Visit to public housing project
- (f) Visit to Division of Housing and Sanitation

Vital statistics

- (a) Introduction
- Value of statistics to medicine (what statistical

methods can and cannot do; examples of false reasoning)

- (b) Methods of tabulating data (distributions, frequency, age, etc.)
- (c) Elementary analysis of data (measures of center and of dispersion; mean, median, probable error, range, fourfold tables, X² test)
- (d) Problem—to be turned in the next week (probably one on significance of difference in results between two methods of treatment)
- (e) Enumeration, registration, and notification (importance and uses)
- (f) Proper method of completing a certificate of birth
- (g) Proper method of completing a certificate of death

(Third Year)

A. Lectures on preventive medicine at the medical college—1 hour per week

- (1) 11 hours on general principles of epidemiology and on the epidemiology and control of the various infectious diseases

Tuberculosis	Smallpox
Venereal diseases	Chickenpox
Diphtheria	Tularemia
Poliomyelitis	Rabies
Cerebrospinal meningitis	Tetanus
Pertussis	Rickettsial diseases
Rubeola	Intestinal diseases
Rubella	Virus diseases

- (2) 11 hours on preventive aspects of non-infectious conditions

Accidents	Heart disease
Orthopedic defects	Perivascular disease
Obesity	Surgery
Diabetes	Radioactive substances
Nutritional diseases	Mental disease
Allergic conditions	Dentistry

- (3) 10 hours on industrial hygiene

- (4) 2 hours on public health law

B. Socio-economic medicine at Philadelphia General Hospital

- (1) Sections of six students for three weeks—one afternoon per week. Students are divided into sections (a), (b), and (c) of 2 each. The sections rotate weekly.

(a) Students are required to study the social and economic status of an assigned patient by visiting the home and investigating the neighborhood.

(b) Students are assigned to the Visiting Nurse Society. They visit the homes of patients where demonstrations on home care as offered by the society are given.

(c) Students are assigned to a physician in the medical services of the Board of Education. They visit a high school, do physical examinations on school children, and learn the medical aspects of the State School Code.

- (2) Discussion periods—2 hours per week. These are held with the students of the above section

and instructors, interns, staff physicians, social workers, and public health nurses present.

The students are required to evaluate the patient studied as a whole, including the socio-economic conditions which they have determined on their visit to the home, and are required to make recommendations to be given the patient upon discharge. The students also report on their experiences with the Visiting Nurse Society and the school medical services.

- C. Aspect of the course in the third year. Students will be required to "survey" a community of 5,000 to 100,000 population which will include total public health and medical care facilities in that community.

those of arthritis or cancer or tuberculosis, and various agencies can be called to assist.

At Hahnemann Medical College, a program has been formulated which will add to the principles of preventive medicine and public health, as taught in the "traditional" manner, this new concept of "socio-economic medicine." Efforts are being made to assist and to collaborate with the various clinical departments which are already teaching some of its principles.

Thus, at Hahnemann, the course in public health and preventive medicine will be given in the second and third years. In the second year the student will be taught the principal accepted pattern of public health programs such as environmental sanitation, infectious disease control,

and biostatistics. He will be taught how a public health agency works and why, and how he and the agency can be of mutual assistance.

In the third year, besides being taught the epidemiology (the natural history—who it happens to and why) and preventive aspects of the communicable diseases, he will be taught the same thing in connection with such, perhaps much more important, diseases and occurrences as heart disease, cancer, diabetes, and accidents. He will be taught the new mechanical and chemical hazards arising daily in industry. He will be shown just what can be done for a patient in the hospital whose home he visits. He will make rounds with visiting nurses. He will help in the daily activities of a member of the medical service of the Board of Education. He will participate in conferences where all the persons concerned from these agencies will knit together the pattern of not only the clinical care of the patient but how all these various agencies can help in getting the patient back to optimum health and keeping him so.

With this program, we hope to remove from the prospective physician the barriers to complete effective care of his patient, and he will be concerned not with curing a disease, but a *person*, much earlier than heretofore.

YOU DID IT—NOW FIX IT!

If you have an overweening ambition which allows you to step on the necks of your colleagues in your scramble toward the top—

If you are not ashamed to be one of those whose exorbitant fees have helped to create the widespread notion that private medical care is an expensive luxury—

If you are content to be a cold and clever technician to whom no person can turn for an answer to any of the thousand little questions which plague his daily life—

If you operate on a patient and then cannot be reached to see him when something goes wrong—

If you have ever dared to say "My price is such and such, either that or nothing,"—knowing full well that no decent patient wants something for nothing—

If you have ever dared to inquire "Don't you think your wife (or baby or father) is worth that much?"—knowing full well that in grief or gratitude the family will not protest too much—

If you have ever been guilty of any such cruel or arrogant conduct, your actions have reflected themselves upon all the others in your profession. You personally are in some measure responsible for such dislikes as the government or the people have developed for the way

medicine is now practiced. And one thing is certain—you never could survive as a family doctor.

On the other hand, there are thousands on thousands of physicians in this country, most of them family doctors, who are energetic but not offensively aggressive, who weed out the chiselers among their clients, but scorn to load extra charges on honest patients. They are the men and women to whom the community turns for help in small matters as well as for succor in grave crises. These men are apt to be simple in their tastes and kindly in their outlook, never hard-eyed and ostentatious. They are willing to give and take as necessity demands. They do the bulk of all medical work, carefully and without stint. The irony is that as today's political squirrel cages whirl, it is they and not you who are more likely to be thrown off and broken like their brothers in other lands.

Well?

If you think there is no public relations problem, you are wrong. If you think you are not a responsible party, you are doubly wrong. To avoid expropriation of medical practice by the government, you have one course—in all dealings with your patients be governed by the Golden Rule. It saves wear and tear, and it is good business.

For the sake of American medicine, consider this seriously.—*Norfolk Medical News.*

Hysterectomy—Indications and Contraindications

ELVIN J. BATEMAN, M.D.

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THE HUMAN uterus has a single physiologic function and that is childbearing. Adjunct to this is the menstrual function. It has an anatomic function in that its supporting structures also aid in supporting the upper vagina, bladder, and rectum. It has no endocrine function of its own, being merely acted upon by hormones produced by other organs. It has been apparently established that it produces during its menstrual life a pseudo-hormone called menstrual toxin or menotoxin, which sometimes has a deleterious effect upon some individuals.

The physiologic effects of a properly performed excision of the uterus are cessation of childbearing and of menstruation. Menopausal symptoms may manifest themselves sooner than they otherwise would or may not occur at all. The frequently mentioned post-hysterectomy degeneration of the ovaries is due to lack of care in preserving unimpaired the main ovarian blood supply.

Marked psychic depression, nervous disturbance and, in extreme cases, melancholia may result unless the individual is carefully impressed beforehand that she will suffer no change in the manifestations of her nervous system, that no bodily changes will take place, that she will not get fat, that she will not grow a beard or develop a man's voice, and that her sexual ability will be unimpaired.

Vaginal removal of the uterus has been practiced for at least 300 years and probably much longer. Abdominal hysterectomy has been performed over 100 years. With the near perfection of the present-day anesthesia, adequate preoperative preparation, and simplification of operative techniques, the operation has become one of the safest in the surgical catalogue, even for the surgeon of only moderate skill.

Inevitably these factors have resulted in vastly widening the indications for the operation and a

tremendous increase in the incidence of these operations. Inevitably also, and perhaps belatedly, criticism has appeared. There is a feeling that perhaps the indications have been broadened too much and that the incidence is possibly too great. Some of this criticism is justified. Much of it is not. Some of the articles written in criticism of hysterectomy are scholarly and scientific discussions of the properly accepted indications for the operation and able analyses of statistics. Others are sadly sophomoric and give evidence only that the writer feels that many unnecessary hysterectomies are being performed, almost exclusively by his local competitors.

Criticism of the indications for this or any other operation is usually based on a review of the intern's history and the pathologist's report in the hospital records of a large number of patients. Each of these, potentially at least, may be grossly unfair. How can anyone, trying to review a stack of charts half the size of a bale of hay, have any conception of whether the history he hurriedly skims over represents the report of an intern who has had plenty of time to sit with the patient and carefully elucidate her symptoms and complaints, or whether it represents the hurried effort of a young man to fill the page so he can get on to fifteen other histories which have to be done the same evening and who was interrupted four times, in his labor of love, by the telephone at that. Likewise in a statistical survey the use of the pathologist's report as a sole basis for judging the justification or lack of it for any operation may also be very unfair. What can a pathologist, peering through his microscope at a section of uterine wall and carefully noting the phase of the endometrium and the absence of tumor and inflammatory cells, sometimes ignoring the proportion of connective tissue to smooth muscle and the degree of sclerosis of the small arteries, know of the discomfort, pain, degree of prolapse, or protracted periods of bleeding, or the prolonged period of unsuccessful treatment

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which has preceded operation in an effort to cure the patient from whom the organ was removed.

The study of hospital charts for the purpose of evaluating a hysterectomy or any other surgical procedure is of no significance unless each and every chart in the series contains a statement by the operating surgeon detailing all his previous contacts with the patient, the symptomatology, findings on examination, and all previous treatment and results. The intern's history should either confirm this or uncover additional facts and any discrepancies should be satisfactorily explained. All this information should be available to and used by the pathologist.

If the critics are right and too many hysterectomies are being performed, two facts must be bluntly faced. Either the unwarranted operations are done by dishonest and unscrupulous surgeons or by surgeons not yet fully acquainted with the value of present-day mechanical, medical, endocrine, psychosomatic, and minor surgical procedures which will relieve the complaints of many women whose ailments were formerly held to require hysterectomy. I personally know of no dishonest surgeon. I feel that the number of such must be very small. If one should be found in a community, his hospital staff and county medical society possess the means of dealing with his activities and should have the courage to do so. Continuous postgraduate education, worthwhile medical meetings, and attention to current medical literature provide the answer to the other side of the problem, for no individual doctor stands still for a day in professional attainment. The day that he does not move forward is a day in which he moves backward. Those few who make no effort to keep up with progress inevitably eliminate themselves for consideration.

If further criticism of the frequency of hysterectomy is to be avoided, it might be well to stop now and give consideration to exactly what are the accepted indications and contraindications for this operation. Solely for the purpose of stimulating thought and discussion of this problem, while disclaiming entirely any of the attributes of the oracle, I have presumed to list the most generally accepted indications for hysterectomy and will later discuss what I consider to be its contraindications.

Few physicians will disagree with the statement that hysterectomy should be performed whenever possible for malignant tumors of the body of the uterus, albeit the operation should usually be preceded by radiation. Likewise the

uterus should be removed in conjunction with the excision of malignant tumors of the ovaries. All large fibroids should be removed and, unless they are solitary or pedunculated or otherwise exceptional, hysterectomy is the preferable operation. In patients over the age of 35 with small fibroids causing persistent bleeding which will not cease with the use of endocrine products and repeated curettage, hysterectomy should be done if the patient's appearance and general condition suggest that preservation of ovarian function is desirable. The uterus must be removed in cases of really extensive pelvic endometriosis. Also, removal of the uterus may be necessary in some cases of pelvic tuberculosis.

Hysterectomy is an acceptable treatment and often the only satisfactory treatment in complete or near complete prolapse in older women, in conjunction with cesarean section in grossly infected cases, in functional bleeding in patients over 38 whose bleeding will not cease under any other treatment and upon whom other treatment has been tried for a sufficient length of time to demonstrate its futility. Likewise it may at times be the proper procedure in conjunction with bilateral salpingectomy and occasionally is necessary for the relief of persistent pelvic discomfort, pain, bleeding, and dysmenorrhea in those who have previously undergone salpingectomy. There are cases in which the uterus is large and boggy, partly prolapsed, with a grossly diseased cervix in patients who have almost continuous lower abdominal pain, discomfort, and backache and who may also need an extensive outlet repair, where hysterectomy may well be done. There is a small group of women over 35 who experience a severe disabling acquired dysmenorrhea preceded by severe premenstrual tension, headache, abdominal pain and distress—a menotoxic train of symptoms which brings forth a dread of each recurring period which amounts almost to a psychosis. To these women, hysterectomy is a godsend, but the most careful study and prolonged attempts at palliation are necessary before recommending the operation. In addition, in the hands of the most expert, the revived Wertheim operation may be done, at least until its status can once more be evaluated.

Hysterectomy is definitely contraindicated as a treatment for functional bleeding in young women. It is not required for small symptomless fibroids. Likewise it is not the treatment of choice for menopausal bleeding or small bleeding

fibroids in women of menopausal age. I feel that radiation is the treatment of choice for this condition, in spite of the fact that occasional instances of the development of carcinoma of the fundus in those who have undergone radiation have come to light. The number of such cases, at present at least, seems to be insignificant and besides the most carefully reported cases of this kind mention the inadequacy of the radiation dosage employed. Many women can be relieved of pelvic symptoms and spared hysterectomy by proper treatment of the chronically inflamed cervix, by pessary treatment of minor prolapses, by dilatation and curettage, by medicinal treatment, including the endocrine preparations, by frequent hot douches, and occasionally by psychotherapy based on a sympathetic understanding of an individual woman's possible environmental or domestic discords, her personality, general health, and day-to-day existence.

Broadly speaking, hysterectomy is contraindicated in women of the childbearing age unless

there is strong reason to believe that sparing the uterus means jeopardizing the woman's future health. The finest clinical judgment is often called for in deciding this point. Certainly it should preclude hysterectomy as a short cut in the treatment of patients with annoying but minor pelvic complaints. However, preservation of the childbearing function should not be made a fetish. There is no point, for example, in reducing a uterus by multiple myomectomy to a mangled mass of tissue incapable of any function and sure to serve as a focus for the formation of crippling adhesions.

The question of contraindications to hysterectomy can really be summed up in a single sentence: Every time a surgeon contemplates the performance of a hysterectomy, he should ask himself this question, "Would I want this operation performed on my wife or my daughter for the indications here presented?" Unless the answer is an unqualified "yes," some other form of treatment should be sought.

BATTER UP!

The baseball season is here again. Ball parks are open and are crowded with fans screaming for hot dogs and home runs. Before the first play of every game a hush hangs suspended in the stands as all eyes are on the pitcher. The hush stretches through the windup and then breaks as the pitcher lets go. From the moment the ball leaves his hand, the game is on. But only for the fans—the public. For the players, the game is in full swing as soon as the pitcher picks up the ball. Their trained eyes focus on the windup, and their minds quickly calculate the curve of the ball and the point of the strike.

Baseball players and physicians have a lot in common. Where the ball player analyzes the windup, the doctor analyzes symptoms; where the ball player swings the bat, the doctor prescribes medicine and treatment; and where the ball player comes in for a home run, the doctor saves a life.

Right now the doctor finds himself at bat for his own life; he has been challenged by the standard-bearers of socialism. From his home-plate position, the doctor looks at the pitcher's mound and sees men like Oscar R. Ewing, the Welfare State's mouthpiece; J. Donald Kingsley, Ewing's former aide, Communist collaborator, and present Director General of the International Refugee Organization; and Harry N. Rosenfield, a D. P. commissioner formerly in charge of "selling" the Wagner-Murray-Dingell bill to Congress. Others on the team include a few state and federal legislators, but for the most part they are men who hold appointive positions. The elected administrators who appoint them may be considered as team managers.

In order to avoid a one-two-three-strikes-you're-out destiny, it would seem that our only defense is to solve the pitching technique. Fortunately, we know that the opposition is counting heavily upon discrediting our professional work. We can shatter their hopes by rendering prompt, courteous, and effective service that is beyond criticism. Every big-league team consistently does its best for its fans; it has to, or it loses them. We cannot do less for our patients and expect them to back us in this political game. So remember, SERVICE will stop the opposition. No one wants to pitch to a home run king, and you, Doctor, are batter up!—*The Journal of the Indiana State Medical Association.*

PLASTIC SURGERY AWARD

The Foundation of the American Society of Plastic and Reconstructive Surgery offers *as its 1950 award* \$500 (first prize of \$300, second prize of \$200) and a Certificate of Merit for essays on some *original unpublished subject in plastic surgery.*

Competition shall be limited to residents in plastic surgery of recognized hospitals and to plastic surgeons who have been in such specific practice for not more than five years.

The first prize essay will appear on the program of the forthcoming annual meeting of the American Society of Plastic and Reconstructive Surgery to be held in Mexico City, Nov. 27-29, 1950. Essays must be in before Aug. 15, 1950.

For full particulars write the secretary, Dr. Clarence R. Straatsma, 66 East 79th St., New York, N. Y.

Pennsylvania's State Rheumatic Fever Program

JOHN P. HUBBARD, M.D.

Philadelphia, Pa.

EARLIER this year when I was requested to review for this occasion Pennsylvania's state rheumatic fever program, I expressed some reluctance since I am a relative newcomer in this state and since also I am not directly connected with the State Health Department. However, these very factors were brought forth as favoring an objective point of view and I therefore agreed to discuss this important program.

It is unnecessary at a meeting of this medical society to emphasize the responsibility of the community or the state in meeting the problems of the control and management of rheumatic fever. Pennsylvania has given evidence that it does recognize its responsibility and is doing something about it. It has, in fact, taken a prominent place among the states in the fight against rheumatic fever, a disease which kills more children than any other. Now that the State rheumatic fever program is well under way, it is timely and appropriate to subject it to a critical appraisal.

Any well-rounded rheumatic fever program must start with attention to a basic problem—early detection of cases of rheumatic fever or rheumatic heart disease. It is at this logical point that the Pennsylvania program began.

In recent years, with an increasing realization of the incidence and mortality of rheumatic fever, especially in the northeastern region of the United States, a great deal of importance has been placed upon the school health examination as a means of case finding. For the past four years, the school children of this state have been undergoing a vigorous screening process.

On June 1, 1945, the General Assembly of the Commonwealth of Pennsylvania approved Act No. 425, known as the "School Health Act." This act provides for the complete medical examination of all children of school age, teachers, and other school employees in public, private, elementary, and secondary schools. School children

are examined every other year, namely, first, third, fifth, seventh, and eleventh grades. They must be adequately undressed for all examinations, and examinations must be limited to four pupils per hour.

The medical examiner may be any physician legally qualified to practice medicine in the Commonwealth. (We should note at this point that osteopaths may be legally qualified to practice in Pennsylvania.) In all districts with a population of less than 5000, the school physicians are appointed by the Secretary of Health, and are paid directly by the State Department of Health. In districts with a population of 5000 or more, the physicians are appointed by local school departments with the approval of the Secretary of Health, and they are paid by the local school department which, however, is reimbursed for this expenditure by the Department of Health.

A permanent standard health record of each child is kept on file in the school. This record includes the summary form of medical history and a summary of the findings at the time of each biannual physical examination. Following such examination, parents are notified of any defects found in their children.

All school examiners are also supplied with special report forms known as "Report of Suspected Cases of Rheumatic Fever" or "Rheumatic Heart Disease Found in Public and Private Schools." These forms are filled out in triplicate for all children who give a history of or are suspected of having rheumatic fever or rheumatic heart disease. One copy of this form is retained for the school examiner's file; two copies are sent to the Harrisburg office of the Rheumatic Fever Division, where one is filed and the other forwarded to the rheumatic fever clinic nearest the child's home.

Each child for whom one of these special forms is received is given a number and added to the list of registered cases in the clinic. The Harrisburg office then sends a note to the child's parents recommending that the child be brought in

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 28, 1949.

to the nearest diagnostic clinic if the family physician wishes.

In the same year (1945) the Pennsylvania legislature appropriated \$120,000 annually to the Department of Health for establishing a statewide rheumatic fever control program. Early the next year a division to handle this new branch of public health work was set up in the Bureau of Maternal and Child Health. Since then 15 clinics have been opened throughout the State and others are anticipated. All of them are located in accredited general hospitals. The metropolitan areas of Philadelphia and Pittsburgh were not included in this program on the grounds that rheumatic fever clinics already existed in these two major cities of the State.

The Department of Health has required not only that all clinics be established in accredited general hospitals but that the clinic directors be physicians who are certified either by the American Board of Pediatrics or the American Board of Internal Medicine. Most of the present directors are internists and many of them have qualified for specialization in cardiology. Each clinic director practices in the locality where the clinic is established and is a staff member of the hospital in which the clinic is held. Although the clinic directors are chosen by the Department of Health, they must also be approved by the local county chairmen of the political party in power. The establishment of a rheumatic fever program by the Department of Health has been approved by the State Medical Society and no clinic has been opened without approval of the local county medical society.

In addition to a director, the other personnel provided for each of the clinics are one or two public health nurses and a secretary. Clinics are held two mornings or two afternoons each month.

All persons under the age of 21 years who have, or have had, or are suspected of having rheumatic fever or rheumatic heart disease are eligible for the services rendered by the rheumatic fever program. Up to the present time the activity of the Rheumatic Fever Division of the State Department of Health has centered chiefly in registering the names of as many persons as possible who fall into the above categories, and in verifying or ruling out the diagnosis of rheumatic fever or rheumatic heart disease in these persons.

For purposes of registration, individuals may be referred from almost any source—family physicians, school medical examiners, school nurses,

public health nurses, examiners of the pre-school health centers, clergymen, or even the patients' parents themselves.

As of recent date, April 5, 1949, the Rheumatic Fever Division of the State Health Department had a total of 7839 children under the heading "Report of Pupil Having a History or Symptoms of Rheumatic Fever or Rheumatic Heart Disease." All of these names had been sent in by the school medical examiners. In addition to these, there were 2748 children referred to the rheumatic fever clinics from other sources—family physicians, school nurses, public health nurses, and in some cases the children's parents themselves. Thus a grand total of 10,587 names had been collected in the rheumatic fever and rheumatic heart disease register in a little over three years since the program was initiated.

During 1948 there were 1538 children examined in the clinics. Despite this heavy case load, the number referred to the clinics is so much larger than the clinics can handle promptly that there is a continuous backlog of children waiting several months for examination.

It is of particular interest to note how many of the children referred to these rheumatic fever clinics turn out to have rheumatic heart disease. From the information supplied by the State Health Department, it appears that 811 of the 1538 new cases in 1948 were listed as having some evidence of rheumatic heart disease or, in other words, slightly more than half of those examined. It is also of interest to note that the proportion of clinic patients with a diagnosis of rheumatic heart disease varies greatly from clinic to clinic. In some clinics less than half are diagnosed as rheumatic heart disease, in others over 90 per cent. These wide differences may be explained in part by variation in the sources from which referrals are received. Some of the clinics have a large number of cases sent in by general practitioners, who seek consultant advice and confirmatory laboratory and x-ray examination for patients already known to be rheumatic. Such clinics will, of course, have very high percentages of positive diagnoses. On the other hand, a comparatively low percentage of positive cases will be reported from a clinic which receives patients mostly from school health examinations in which the examiner places too much importance on the presence of a heart murmur, which later turns out to be interpreted as functional.

If, then, so many children are found not to

have rheumatic heart disease in the state clinics, some of the implications of this situation warrant careful consideration. By way of illustration, let us follow the course of events for a child who is undoubtedly one of many. He has been thought to be a healthy, normal child until, at the time of a school health examination, he is found to have a precordial systolic heart murmur. Because of this finding, the examining physician fills out a card headed "Report of Pupil Having a History or Symptoms of Rheumatic Heart Disease." Duplicate copies of this card are sent to the Harrisburg office, the child is added to the rheumatic fever and the rheumatic heart disease register, and the parents are notified. The parents then get in touch with the family physician. Let us assume that he has known all along that the child has had a heart murmur, which he has considered functional. Now, however, doubt has been raised. Not only the parents but also the child himself have become apprehensive. To dispel the doubts and fears, the child is sent to the state clinic, which incidentally will cost his family nothing. There, a specialist familiar with the disease and full diagnostic facilities are available—blood count, sedimentation rate, electrocardiogram, x-ray, and fluoroscopy. Let us assume further that all tests are normal, and that the heart murmur is again considered to be functional in nature. A note is then sent to the family physician confirming his original opinion.

All this has not been done without doing real harm to the impressionable child. It takes but a moment to plant the seed of doubt; it takes a lot of convincing and extensive laboratory procedures to remove this seed of doubt.

The cost to the State of maintenance of these diagnostic clinics is of very practical importance. It has already been mentioned that the annual appropriation for this purpose is \$120,000. If the total amount of this appropriation is used during the course of the year, it is rather simple arithmetic to calculate that, for the 1538 new cases examined, it costs approximately \$78 for each child examined in the state clinics.

At this point I wish to have it clearly understood that any child with signs or symptoms of rheumatic fever or rheumatic heart disease has a right to have a careful and thorough examination at whatever cost. But this does not mean that all children with heart murmurs should be put through the elaborate and disturbing procedure outlined above. To do so would subject half the school population of the State to examination in

the rheumatic fever clinic, for it has been well established by a number of studies that about half of all children have functional heart murmurs which are of no significance.

How are we to assure that the child who really does need the services of a diagnostic clinic gets to the clinic, that the child with a functional heart murmur is spared this trial, and how can the excessive per capita cost of the present program be reduced?

In my opinion there can be only one answer. The physician who examines the child in the school must be given an opportunity to become more thoroughly familiar with the vagaries of this disease. He must be made to realize that he assumes a grave responsibility if he makes a diagnosis of rheumatic fever or rheumatic heart disease, a diagnosis which carries with it serious implications for the future well-being of the child.

There are several methods by which practicing physicians may be given a fuller knowledge of the protean manifestations and importance of this major disease of childhood. Postgraduate seminars may be established in which the school physician spends a few days devoted to a review of rheumatic fever and heart disease. This is a shot-in-the-arm type of postgraduate teaching. It is of recognized value, but its value is limited.

A more effective and continuing method of bringing these physicians closer to the problems involved, and one which goes to the root of the matter, is to meet the problem where it originates—at the school itself. The State would be spending less money and doing more good if it were made possible for consultant physicians thoroughly familiar with the disease to visit the schools and examine doubtful cases on the spot, together with the school physician. A large number of cases could then be sifted out and called normal, even without the need of sedimentation rate, x-ray, or electrocardiogram. It must be admitted that all too often these laboratory procedures are done more to impress the family or the referring physician than for the good of the patient. In the absence of a specific diagnostic test for rheumatic fever, there is no substitute for the acumen of the experienced physician, and this can be applied just as well at school as when surrounded by laboratory tests which, in respect to this disease, are so apt to be negative anyway.

If this procedure were to be carried out, the excessive and increasing load on the diagnostic clinics would immediately be diminished. The

services of these clinics, with their high per capita cost, could then be reserved for a more carefully selected group of children who present real diagnostic problems.

Still another possible way of providing post-graduate teaching, one which should supplement but not replace either of the two mentioned above, involves the development of local educational activities centering in and around the clinics themselves. To the extent that the referring physicians can be encouraged to attend the diagnostic clinics, to bring rather than to send their patients to the clinic, an opportunity may be provided to discuss with the clinic director the diagnosis in relation to the physician's own patient. Such discussions, if properly conducted, would be of considerable value not only to the referring physicians but also to nurses, social workers, and the clinic director himself.

In conclusion, it may be stated that so far the program has concentrated almost entirely on diagnosis rather than on prevention, care, and treatment. The program, of course, is new, which accounts for this shortcoming. There is good reason to believe that the Secretary of Health is well aware of the shortcomings of the program, and is aware of the need for revision of the case-finding methods, for the development of a follow-up program, for professional and lay education, and for remedying the existing woeful inadequacy of facilities for the convalescent management of rheumatic children. It is earnestly to be hoped that in the following years the State Health Department, together with the Medical Society and the newly organized Pennsylvania Heart Association, will advance along a common front and develop a state rheumatic fever program that is second to none.

VIGOROUS DEFENSE WITH SPIRITED COUNTERATTACK

"We need—and we must have without further delay—a system of prepaid medical insurance which will enable every American to afford good medical care."

With these words, President Truman, in his "State-of-the-Union" message to Congress on January 6, made it clear that he has not changed his mind about compulsory sickness insurance.

As the American Medical Association's nation-wide educational campaign takes shape, it is becoming increasingly evident that a great part of the burden of telling the story of American medicine to the public will have to be carried by state and county medical societies. As a spokesman for the American Medical Association put it in a recent letter, "Your state association and your office, as well as your member societies, will be in the front lines of the 'grass roots' campaign to convince the American people that voluntary medical care is better for them by far than any compulsory system."

No doctor should feel that the payment of the \$25 assessment puts an end to his responsibilities. That is just a start. There is a big job to be done and one which requires every resource that the doctor and his professional organizations can marshal.

The time to act is *now*. Compulsory sickness insurance shapes up as one of the most important issues of the year. The government planners are lining up their big guns for an all-out attack upon private medicine. They cannot be repelled by half-hearted measures. It will take a vigorous defense and a spirited counterattack.

The presidents of the county medical societies and their fellow officers should analyze the situation in their localities and organize their facilities to meet it. There are two things which each county organization should concentrate upon immediately. These are:

1. Organization of a speakers' bureau.
2. Creation of a public relations committee where one does not now exist.

It is highly important that speakers be made available to disseminate the facts of our case to the American people. A call should go out to all members with forensic ability to volunteer their services for this purpose. It is equally important to have an effective public relations committee to map out a well-rounded program of activity to meet this emergency and to act as a channel for the information which is flowing in increasing quantities from a number of sources on the subject of compulsory sickness insurance.—News Letter of Medical Society of the State of New York, Jan. 12, 1949.

"Virtually all medical insurance or social medicine programs are 'sold' on the basis that the patient can still choose his own doctor. The catch in this seems to come when a patient wants to change doctors. Such a contingency is provided for, of course. But anyone who has had experience with the 'paper work' involved in government processes realizes that a great measure of freedom to act goes out the window when it is necessary to fill out forms in quadruplicate and wait for 'official approval' before moves can be made."—*Mansfield (Ohio) News Journal*.

Choice and Use of Chemotherapeutic Agents in General Practice

EDITOR'S NOTE: Under the above title, we are permitted to publish several summaries from a paper read by John A. Kolmer, M.D., at the 1950 Postgraduate Institute of the Philadelphia County Medical Society. Dr. Kolmer comments:

"While a large number of sulfonamide and sulfone compounds are available, yet clinical experience has more or less clearly defined their choice in the treatment of various bacterial infections. Furthermore, until the discovery of aureomycin, chloramphenicol (chloromycetin), and bacitracin, antibiotic therapy of infectious diseases was merely a choice between the administration of penicillin, streptomycin, or both. Nowadays, however, accurate clinical and/or laboratory examinations, along with clinical experience, are more important than ever in the choice of the antibiotic or combination of two or more chemotherapeutic compounds to be employed in the treatment of bacterial, spirochetal, rickettsial, and viral diseases."

5. *Natural and Acquired Resistance in Chemotherapy*

Naturally resistant variants among susceptible species of bacteria are frequently responsible for treatment failures. They are detected by sensitivity tests. When present, give larger doses or change to another compound.

Bacteria do not usually or readily acquire resistance to penicillin *in vivo*. Resistance to the sulfonamide compounds and streptomycin is readily and frequently acquired.

Bacteria may acquire resistance to bacitracin, aureomycin, and chloromycetin, but the incidence is unknown. Whether or not the rickettsia and viruses acquire resistance *in vivo* cannot be stated at the present time.

6. *Causes of Treatment Failures in Chemotherapy*

Mistaken clinical and/or laboratory diagnosis.

Infections due to organisms possessing high natural or acquired resistance.

Dosage too small, intervals of administration too long, or duration of treatment too brief.

Overwhelmingly severe infections or too long delay in treatment.

Inadequate surgical measures or failure to use other adjuvant measures of helpful value.

Localization of infections in areas inaccessible compounds administered.

Occurrence of spontaneous new infections or superinfections indicating the frequent need for repeated bacteriologic examinations during treatment and convalescence (especially in the event of relapse).

7. *Bacterial Sensitivity Tests in Chemotherapy*

Frequently required for the detection of natural or acquired resistance of bacteria isolated from patients and especially when unsatisfactory therapeutic results are observed.

The paper disc method of Bondi is a satisfactory, cheap, and technically simple method for routine use. With this method the sensitivity or resistance of organisms to aureomycin, bacitracin, chloromycetin, penicillin, and streptomycin may be determined simultaneously.

It may also be used routinely in petri dish cultures for diagnostic purposes. This enables the laboratory to report the kind or kinds of organisms present along with their susceptibility or non-susceptibility to each of these five compounds at the same time. It is also possible to include neomycin and terramycin.

This disc method, however, cannot be employed with the sulfonamide compounds because of their non-diffusibility in solid culture media.

This series of summaries began in the May PENNSYLVANIA MEDICAL JOURNAL and will be concluded in the July issue under the titles: 8. Blood Level Assays of Sulfonamide and Antibiotic Compounds in Chemotherapy; 9. Carinamide in Penicillin Therapy; 13. Combination Chemotherapy (Synergistic or Additive).

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EDITORIALS

A CONVERT EVERY WEEK

Depend on No One to Carry Your Share

For several years the Michigan State Medical Society (4804 members) has underwritten its public relations program by an annual \$25 assessment from its membership in addition to annual membership dues. Yet the March 27 issue of *Detroit Medical News* (Wayne County Medical Society—2800 members) states:

"Over four out of ten people in Michigan have not heard of nor read of the Michigan State Medical Society.

"Only one of five persons has ever heard of a community health council, but the majority of people believe that such an organization would be a good idea.

"Fewer than one out of four people know that the radio program 'Tell Me, Doctor' is sponsored by the Michigan State Medical Society, but four out of ten who know of it listen at least once a week.

"It seems that the doctors of Michigan still have a tremendous publicity job to do!"

These four postulates should not discourage Pennsylvanians but rather encourage our State Society members to adopt and consistently activate two activities: (1) *win one person each week* to the principles of democracy and the acceptance of voluntary forms of insurance; (2)

claim the assistance in each county society of the local services of the field representatives of the state society's Committee on Public Relations (to 16 central Pennsylvania county societies—Mr. Leo E. Brown, 230 State St., Harrisburg; to 25 eastern Pennsylvania county societies—Mr. Gar Young, 301 S. 21st St., Philadelphia; to 26 western Pennsylvania county societies—Mr. Keith Hutchison, Jenkins Arcade, Pittsburgh).

The New York State Medical Society employs three field representatives under the direction of public relations. They personally contact the officers and representatives of the county medical societies, pick out the live wires, display interest in them and describe what can be done for and by them. That society evaluates them as follows: "Nothing else we have ever done compares with the favorable results we get from these men."

When such field workers are called into a county, it should be remembered that they alone, as professional public relations workers, be it in a small or large community, cannot make any considerable impression on the total mass of public opinion. If, however, as suggested above, 10,000 Pennsylvania doctors were to win a minimum of one "convert" each week, a half-million pledged supporters would be gained annually for the *voluntary* cause and for *thrifty living* at community levels in the State of Pennsylvania.

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

EVALUATION OF PULMONARY FUNCTION

Medicine has passed from the age of anatomy to that of physiology. Countless investigations into all the ramifications of disturbed function in disease have led and will continue to lead to new life-saving therapeutic procedures. Stimulated by the contributions of Cournand and Richards, many able investigators have added recently to our understanding of pathologic physiology in pulmonary diseases.

It is now possible to determine by precise laboratory tests the ability of the lungs to perform their essential functions of ventilation and diffusion. The transportation and uniform distribution of air to all alveoli is termed "ventilation" and the interchange of oxygen and carbon dioxide across the capillary membrane is called "diffusion." Disease may adversely affect both of these functions or impair one of them selectively. By measuring quantitative decrease in pulmonary function, information is obtained concerning the degree of pulmonary reserve. It has been known for many years that the heart, kidneys, and liver, for example, may appear to be performing their functions quite adequately despite loss of a large number of functioning units. Eventually, this reserve becomes exhausted and symptoms of insufficiency develop. It is now evident that the same process occurs in the lungs, and that some idea of the degree of structural damage may be obtained by tests of pulmonary function even before symptoms of incipient or well-developed pulmonary failure occur.

Knowledge such as this is indispensable for proper evaluation of the status of a patient scheduled for thoracic surgery, be it for cancer, bronchiectasis, or cardiac anomalies. Furthermore, a more accurate appraisal of pulmonary capacity in many medical conditions reveals the importance and varied manifestations of emphysema. It is not unlikely that some aspect of pulmonary emphysema is present in most individuals over 45 years of age and that it often exists as a complicating and frequently decisive factor in many other disease conditions.

Lastly, it should be emphasized that the physiologic approach to pulmonary disease should be uppermost in the minds of physicians. Even when detailed laboratory tests of quantitative pulmonary function are not available, careful physical examination and fluoroscopic and roentgenographic examination directed to a demonstration of functional capacity will yield impor-

tant information of a qualitative nature regarding pulmonary physiology. And, it may be added, the detection of qualitative differences remains the art of medicine.

ROBERT P. BARDEN, M.D.

FLUORIDATION OF DRINKING WATER

A request received recently from the Fayette County Medical Society for information on the addition of fluorine to the drinking water supply of a community was referred by the secretary-treasurer of the State Society to the Department of Health of Pennsylvania, and brought forth an instructive response from which we quote generously:

"An inverse relationship appears to exist between the fluoride content of natural waters and the prevalence of dental caries. Recognition of this relationship led to the proposal that fluoride be added, as a caries control measure, to waters deficient in that constituent. . . .

"The American Water Works Association in 1949 gave official acceptance to the practice of water fluoridation for the purpose of reducing tooth decay. A special committee recommended a policy which was approved by the association as follows:

"In a community where a strong public demand has developed and the procedure has the full approval of the local medical and dental societies, the local and state health authorities, and others responsible for the communal health, the water departments or companies may participate in a program of fluoridation of the public water supplies."

"The committee report also indicated that the cost of fluoridation may properly be charged against community health expenditures.

"In Pennsylvania we have received no formal applications requesting approval for the fluoridation of public water supplies. . . .

". . . At the present time seventeen projects are in operation in the public water supplies of nine states and fourteen additional installations are being considered at the present time. The Board of Trustees of the Pennsylvania State Dental Society, at a meeting held in Philadelphia Jan. 31, 1950, adopted the following resolution:

"That the Pennsylvania State Dental Society advise the Pennsylvania State Department of Health to grant proper authority to communities to fluoridize their drinking water on an experimental basis, and that proper statistical record be kept by some authorized body of the community."

"As you know, the Pennsylvania Department of Health has supervision over the public water supplies in Pennsylvania, and therefore must approve any new water supply, any changes, extensions or additions to existing water supplies. This would include the addition of fluorine to the public water supply. . . .

"An application shall also be accompanied by detailed plans of the apparatus to be used in the application of the chemical, the location of the apparatus with respect to other units of the water treatment plant, and shall clearly indicate the point of application of the chemical.

"Upon receipt of such an application the engineers of this bureau will study the particular conditions involved and take appropriate action.

"It is obvious from the foregoing that this department must deal with the water purveyor, and any permit approving the process will require that the water purveyor assume responsibility for the accurate control of the introduction of the chemical into the water supply."

L. D. MATTER,
Assistant Chief Engineer,
Department of Health,
Commonwealth of Pennsylvania.

CRIME AND PUNISHMENT

Crime has engaged the attention of society from time immemorial. Punishment, at times more severe, and in recent years more lenient, has admittedly proved itself insufficient to halt criminal activity. It was believed, however, that punishment did act as a deterrent at least in some cases. But in recent years a new school of thought has arisen which denies that punishment does even that much. The adherents of this school, apparently under the impact of modern psychiatry and particularly psychoanalysis, have gone to the other extreme and advocate that punishment should be abolished and that criminals should be sent to institutions for treatment.

Recently, the writer heard a debate on the radio between an officer of the law and the director of the Society for Prevention of Crime. The director maintained the extreme point of view expressed above. The law enforcement officer had the much more realistic, even if conventional, approach to the entire problem, whereas the director in a very dogmatic manner defended the point of view that criminals, all criminals, are sick people and should be institutionalized for treatment.

There does not even seem to be a doubt in the mind of these people as to the correctness of their attitude. Even if they were right, there would not be enough psychiatrists and psychoanalysts to handle the load, let alone the finances to meet such a burden. But, so far, these people only offer theories which have not even been tested sufficiently, let alone proved.

From a practical standpoint, the writer, him-

self a psychiatrist, must admit that the views expressed by the officer of the law are far more practical and sane in the method of handling the criminal in our midst.

Psychiatry has made great progress but it does not have, and it should not claim that it has, all the answers to the crime problem. The experience accumulated by society through the ages is valuable and cannot be discarded so lightly for theories which, by and large, still have to prove themselves.

MAX H. WEINBERG, M.D.

A THERAPEUTIC SUGGESTION FOR SUCCESSFUL MANAGEMENT OF PSYCHOSOMATIC DISORDERS

Contemporary literature lays considerable emphasis on the inseparability of mind and body, although such a conception of clinical manifestations was known and expressed by some writers even in the seventeenth century. Morton and competent subsequent authors such as Gull, Lasègue, and many others, considered the malfunctioning of a body as a reciprocal effect of emotions and physiologic action. Observations of this character have gradually accumulated, all proving the correctness of this contention. Some difficulty, however, is experienced in determining which of the two processes plays the primary or original role—the physiologic or psychologic structure. The solution of this question would naturally have a considerable bearing on the therapeutic management of psychosomatic cases.

A careful analysis of the observations recorded in the literature does not permit a well-defined conclusion in the largest majority of cases. Confusion follows and therapeutic results are quite uncertain. Recurrences of bodily dysfunction are frequent. This is a common observation. As the problem stands today, the medical camp is divided. Some earnest writers report observations with autopsy material showing anatomic lesions in their cases which, during life, presented striking clinical manifestations of malfunctioning personalities. Others put forward apparent evidences of physiologic dysfunctioning, originated exclusively by disturbing emotional forces. We also see instances in which the pendulum swings at one time in the direction of a psychogenic origin, at another time in the direction of somatic origin. Naturally, such a variety of pathogenetic

factors are bound to have their repercussions on the therapeutic approach. Indeed, a great variety of the therapeutic results are being observed.

In reading the descriptions of psychosomatic cases, one is amazed at the strenuous efforts made by the writers to envisage their observations only and exclusively in accordance with their respective preconceived ideas, as if no other interpretation is at all possible. That these efforts are overstretched and overemphasized, it is too evident to ignore. Take, for example, the history of "anorexia nervosa." Simmons considers this clinical phenomenon as due only to the material destruction of the pituitary gland. Others, admitting the role of the pituitary, insist that there is only a functional dyspituitarism. Still others state that this form of anorexia is only a graphic illustration of the influence of emotions on bodily functions; primarily a psychologic and only secondarily a physiologic disorder supervenes. According to the latter conception, powerful psychodynamic forces lead to starvation and emaciation. Such is the nosologic situation of the psychosomatic syndrome called "anorexia nervosa." The same critical remarks are applicable to a host of psychosomatic entities. The contemporary literature contains innumerable examples of this character.

The writer of these pages has been making an effort to avoid overemphasizing one pathogenetic element against another in psychosomatic medicine. He firmly believes that such an attitude cannot have a legitimate place in scientific medicine and that the therapeutic management is therefore bound to lead to undesirable results. He believes that the only method in management of psychosomatic syndromes should consist of *coordinating* the psychic underlying forces and the usual clinical attention to the somatic disorders. He firmly believes that of the two etiologic elements the latter should invariably have *the lead* in our therapeutic efforts. The psychologic requirement must accompany the physical requirement, but only as an accessory measure, in view of the fact that no patient, however intelligent he may be, will be intellectually satisfied with our interpretation of his gastric, intestinal, cardiac, and any other visceral disturbances, as due exclusively to a disorder in his emotional life. Psychotherapy should be practiced in all such cases quite imperceptibly and without a conspicuous and undue emphasis. Desirable psychologic results will be obtained alongside somatic improvement if such a double method in the

order indicated is instituted at the very onset of treatment. Such has been the experience of the writer even in cases with the most pronounced disturbances in the realm of emotional life and accompanied by very mild somatic symptoms.

The attention of psychosomatic invalids of all types is invariably and solely concentrated on their physical disability. Our task therefore is the therapeutic attack on this front first of all. This is a plea for a correct and efficient orientation in the very large field of psychosomatics.

ALFRED GORDON, M.D.

THE MEDICAL SECTION OF THE SCIENTIFIC PROGRAM

In arranging the scientific program for the One Hundredth Annual Session to be held in Philadelphia, Oct. 15-19, 1950, the committee has again emphasized those subjects of particular interest and value to the general practitioner.

The Medical Section will join with the Surgical for six combined meetings on subjects that are much in the medical literature at the present time including hepatic cirrhosis, antibiotic therapy, peripherovascular disease, ulcerative diseases of the small and large bowel, tuberculosis, and cancer management. Several carefully selected speakers from various parts of the country and from our own society have been chosen to take part in these symposiums.

In addition to the combined meetings, there will be six sessions of the Section on Medicine. Here, presentations from all the medical specialties have been included to give a well-balanced program, keeping in mind, however, their value in the general practice of medicine.

Special attention was also given when planning the program to recent significant advances in the field of internal medicine. The role of histamine and the antihistaminics in medicine is given some prominence, and among the speakers discussing this subject will be Dr. Will C. Spain, of New York City. The anticoagulants have not been neglected and will be discussed by Dr. Irving S. Wright, of New York City, under the title of "The Use and Abuse of the Anticoagulants." Dr. Clayton B. Ethridge, of Washington, D. C., will discuss the subject "Coronary Artery Disease."

Of course, no medical meeting would be complete at this time without a discussion of cor-

tisone and ACTH. Dr. Russell L. Cecil, of textbook fame, will discuss these drugs when he presents "The Treatment of Rheumatoid Arthritis." His conservative and practical judgment of them, based on extensive experience, will be much valued.

These are only samples of the high lights of the meeting. Altogether, the program reads like a galaxy of teachers of medicine. The general practitioner, as well as the specialist, will find much to hold his interest.

JOHN H. WILLARD, M.D., *Chairman*,
WENDELL J. STAINSBY, M.D., *Secretary*,
MEDICAL SECTION.

PROTEIN IN NUTRITION

(EDITOR'S NOTE: This is the third of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania. With the present-day interest in applied physiology as displayed by clinicians, this series on its nutritional phase should prove timely, interesting, and instructive. This editorial is packed with sage advice to the practitioner tempted to adopt intravenous feeding of amino acids before prescribing a nutritious diet adequate in protein*.)

Clinical interest in nutrition has always accompanied the rapid expansion of fundamental knowledge in a particular field of metabolism. During the last three decades attention has been focused first on carbohydrate, then vitamins, and now protein metabolism.

It is perhaps fitting that protein nutrition has now received such a marked increase in interest. The name protein is derived from *prōteios*, meaning of first importance. Proteins within the body fulfill a variety of functions: many of the hormones are proteins; enzymes, the mediators of metabolic reactions, are proteins, while other proteins of a characteristic nature are concerned with structural or other specialized functions.

We know, from the fundamental work of Whipple, Schoenheimer, and many others, that proteins in the body are not static, but are in a dynamic state of equilibrium. There is a continuous breakdown and resynthesis occurring, and a variety of influences can affect these processes. We do not know, however, the extent of change that is compatible with normal functional activity in health and disease.

One year ago W. C. Rose announced the quantitative requirements for the amino acids essential to maintain nitrogen balance in normal human adult nutrition. The qualitative requirements had been determined during the last decade. The diets employed furnished an adequate supply of

nitrogen for the synthesis of the non-essential amino acids. The strictly tentative recommended daily intake, in grams, under optimum conditions for nitrogen balance are: isoleucine 1.4, leucine 2.2, threonine 1.0, lysine 1.6, methionine 2.2, phenylalanine 2.2, tryptophane 0.5, and valine 1.6. These are the same amino acids previously found essential for maximum growth in the rat, with the exception of arginine and histidine. Whether these latter two, as in the rat, are not needed for adult maintenance but may be required for growth in the child still remains to be determined.

The above data were obtained under ideal conditions with healthy individuals ingesting a diet complete and adequate in all known respects. The extent and degree of change in requirements that will occur under the stress of illness is unknown. Nor is it known whether there are specific needs for individual amino acids in particular disease states.

Cannon has stated, upon the basis of laboratory experience, that "dietary protein constitutes a major immunologic contribution to antimicrobial defense, whenever there is severe tissue protein deficiency and a concomitant impairment of the mechanisms of immunity." These same observations undoubtedly hold true in human experience.

It is widely appreciated that improvement in protein nutrition increases the ability of an individual to withstand illness, lessens operative risks, and hastens convalescence.

With all the criteria at present available, there is no certain way to evaluate the absolute and specific protein nutritional status of an individual. Hypoproteinemia is a ready although not always reliable index of the extent to which the body's protein reserves have been depleted. A careful clinical and nutritional history will tell as much, and often more, as to the relative state of protein nutrition, than many of the single laboratory procedures currently employed.

When an improvement in the protein stores of a patient is indicated, the adequacy of the clinical diets should be evaluated in terms of the time during which such a regimen will be required. Only when the oral or orojejunal route of administration is not available, or when further supplementation is necessary, should parenteral feeding be employed. This choice is dictated by the greater opportunity of adequately supplying other essential nutrients besides protein. Calories, in particular, are of major importance. If

they are not supplied in sufficient amount, the protein fed will be metabolized for energy and not used for anabolic purposes. In some situations one can question whether we do know the actual caloric needs of the sick individual.

For intravenous feeding there are several preparations available that are satisfactory sources of amino acids. These materials have been shown to be utilized, and when properly prepared and administered will be metabolically satisfactory. However, it is less certain that they always accomplish what is hoped for, because of difficulties in supplying other dietary essentials, e.g., calories, in adequate amounts.

The parenteral amino-acid mixture should contain all of the essential amino acids, and should be low in the dicarboxylic amino acids. The latter have been implicated as the chief cause of the nausea and vomiting associated with intravenous nitrogen feeding.

There is little doubt that intravenous amino acids are a safe and valuable therapeutic aid in patients with cirrhosis who cannot consume, digest, or absorb an adequate quantity of protein from the diet. It is likely that patients with portal cirrhosis whose ascites has been controlled by modern treatment still suffer from portal stasis, so that any marked diminution in protein intake, or increase in sodium intake, will cause a recurrence of the ascites. The intravenous administration of amino acids, although useful as a therapeutic adjunct, can be employed for only short periods of time. An adequate nutritious diet is still the major factor in the treatment of cirrhosis of the liver.

The use of plasma or albumin as a means of replenishing body protein stores is most wasteful from an economic point of view. Here one must clearly distinguish the oncotic attributes from their nutritional efficacy. Their use is indicated as a plasma colloid, while their nutritional value is definitely of secondary importance. Both plasma and albumin are metabolized slowly, and in a normal manner.

It is difficult to determine when one has replaced the protein stores of a depleted individual. Prompt and spectacular changes usually do not accrue from improving protein nutrition. This does not mean that the patient has not benefited by the attention given to providing additional amounts of this prime necessity of an adequate dietary.

HARRY M. VARS
JAMES H. JONES

KEYSTONES OF PUBLIC HEALTH FOR PENNSYLVANIA

Tuberculosis Control

(EDITOR'S NOTE: This is the sixth of a series of guest editorials planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.)

Much of the tuberculosis control effort in the State of Pennsylvania has been topflight. Pennsylvania has the oldest tuberculosis society in the country. It has produced some of the outstanding specialists in the treatment of this disease. It has an institute which is world-famous in research directed at tuberculosis control. The State Health Department itself was established primarily because of the recognized need for tuberculosis control. Results can be measured in the decline of the mortality rate, in a forty-year period, from 151 to 37 per 100,000 population.

In spite of this excellent record, there can be no room for complacency. For example: (1) The death rate in the negro population is very high, reaching 312 per 100,000 in the age group 20 through 24. (2) Mortality data are not corrected for place of residence, which makes it virtually impossible to define the geographic areas of greatest need for additional control facilities. (3) Although reportable by law, cases of tuberculosis reported each year are numerically just about the same as the number of deaths reported per year. (4) Approximately one-third of the officially reported cases are not known to local health authorities. (5) There is need for more local responsibility in tuberculosis control on a local health unit level. (6) The report decries the small central tuberculosis control staff which administers a large service staffed by relatively high-paid, part-time personnel. (7) Although the Pennsylvania Tuberculosis Society is credited with pioneering in rehabilitation services, the Bureau of Rehabilitation in the Department of Labor and Industry, while very much interested in services for the tuberculous, has, for a number of reasons, not been able to set up a first-rate rehabilitation program.

The report makes four specific constructive major recommendations:

1. That local tuberculosis registers be developed.
2. That it be legally possible for hospital subsidy without regard to economic status of the patient.

3. That the State Bureau of Tuberculosis be enlarged to include three divisions, each with a chief and associate staff.
4. That the State Tuberculosis Society and the local societies abandon public health nursing functions in favor of the development of such services in a single nursing agency, preferably a part of local health units.

Information concerning tuberculosis control activities seems to have been conscientiously gathered, and certainly the recommendations made in this chapter warrant the serious consideration of the State health officials and the medical profession.

I. HOPE ALEXANDER, M.D., *Director*,
Department of Public Health,
Pittsburgh, Pa.

VIRUS DIAGNOSTIC LABORATORY

Free Services to Physicians

In the interest of spreading information to all physicians practicing in the Keystone State, the JOURNAL is glad to publish evidence of a fine diagnostic service freely available for the benefit of patients in or out of medical institutions.

The appended chart is illustrative of the breadth of the diagnostic service on virus and rickettsial diseases by the Reference Laboratory for the Pennsylvania Department of Health in Philadelphia. The Virus Diagnostic Laboratory is a section of the Division of Virology in the Department of Public Health and Preventive Medicine of the University of Pennsylvania School of Medicine. Similar reports will appear in the PENNSYLVANIA MEDICAL JOURNAL at intervals with the hope that Pennsylvania people in every county will be benefited.

VIRUS DIAGNOSTIC LABORATORY

Reference Laboratory for the Department of Health
Commonwealth of Pennsylvania

REPORT OF DIAGNOSTIC ACTIVITIES FOR THE MONTHS OF JANUARY AND FEBRUARY, 1950

Number of specimens	509
Number of patients	294
Number of tests	3097

Breakdown

Place from which specimen was sent	Total patients with positive laboratory findings	Disease Suspected				
		Neurologic	Respiratory	Mumps	Lympho- granuloma	Rickettsial
		Positive Laboratory Findings *				
Philadelphia †	48	14 mumps 1 toxoplas- mosis	11 cold agglutina- tion 1 psittacosis lymphogran- uloma	3 orchitis 14 parotitis	2	1 rickettsial pox 1 epidemic typhus in the past
Pittsburgh	4		3 psittacosis lymphogran- uloma		1	
Camden, N. J.	2	1 LCM ‡		1		
Chester, Pa.	1	1 mumps				
Milford, Del.	1	1 mumps				
Morristown, N. J.	1	1 mumps				
Total	57	19	15	18	3	2

* Tests could not be completed on 60 patients (primarily because of lack of appropriate specimens).

† Includes patients in Philadelphia hospitals; the town of residence of these patients is usually unknown to this laboratory.

‡ Lymphocytic choriomeningitis.

Attention!

YOUR HOTEL RESERVATIONS

Should Be Made NOW!

FOR THE

One Hundredth Annual Session

PHILADELPHIA, OCTOBER 15, 16, 17, 18, 19

<i>Name and Location</i>	<i>Single</i>	<i>Double</i>	<i>Twin</i>
BELLEVUE-STRATFORD, Broad and Walnut Streets (Headquarters Hotel)	\$4.00 up	\$7.00 up	\$9.00 up
PENN SIHERATON, Chestnut at 39th Street	4.00 up	6.50 up	7.00 up
BENJAMIN FRANKLIN, Chestnut at 9th Street	5.00 up	7.50 up	9.00 up
WARWICK, 17th and Locust Streets	5.00 up	.....	8.00 up
JOHN BARTRAM, Broad and Locust Streets	4.50 up	7.00 up	8.00 up
RITZ-CARLTON, Broad and Walnut Streets	5.50 up	8.00 up	8.00 up
SYLVANIA, Locust off Broad Street	4.50 up	7.50 up	7.50 up
ADELPHIA, 13th at Chestnut Street	4.50 up	7.00 up	8.00 up
ST. JAMES, 13th and Walnut Streets	3.50 up	5.50 up	5.50 up
BARCLAY, Rittenhouse Square, East	5.00 up	8.00 up	8.00 up

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager Hotel, Philadelphia, Pa.

You are requested to reserve the following accommodations during the period of the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania, October 15, 16, 17, 18, and 19, 1950, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price

☐ Twin Bed Room with bath ☐ Suite

Arriving at a.m. p.m.

Departing at a.m. p.m.

PLEASE VERIFY MY RESERVATION

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OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*
8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

CALL TO 1950 MEETING

The first meeting of the House of Delegates of The Medical Society of the State of Pennsylvania will be called to order in the Clover Room, Bellevue-Stratford Hotel, Philadelphia, Monday, Oct. 16, 1950, at 10 a.m. Subsequent sessions will be held as decided by the House, except the session for the election of officers on Wednesday morning.

Notice relative to parliamentary requirements for consideration of proposed amendments to the Constitution and By-laws was published in the May JOURNAL.

Three Proposed Amendments to Constitution and By-laws

The Board of Trustees of The Medical Society of the State of Pennsylvania respectfully submits the following amendment to the By-laws for consideration and action by the 1950 House of Delegates:

Resolution

WHEREAS, Experience gained in recent years throughout the State has demonstrated from the greatly reduced attendance upon the traditional annual councilor district meetings a lack of membership interest, and

WHEREAS, The planning requires preparation and mailing of 12,000 individual communications, with a resultant total attendance of approximately only 1000 society and auxiliary members, and

WHEREAS, The annual expense, exclusive of employees' time in the office of the secretary-treasurer, approximates \$1,500, and

WHEREAS, Section 9 of Chapter VI of the By-laws amply defines the responsibilities and the duties of each councilor, who is also a trustee, and if adequately discharged may "increase the organizational zeal of the physicians of each councilor district"; therefore be it

Resolved, That the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania request the 1950 House of Delegates to delete from the By-laws Section 4 of Chapter II, which reads as follows:

SECTION 4.—Each councilor district shall hold one or more district meetings each year for the purpose of increasing acquaintanceship, good fellowship, and organization among the physicians of the district. All physicians residing in the district who are eligible to membership in a component county medical society shall be invited to the meetings.

Section 9 of Chapter VI referred to above as amply defining the duties of the councilors reads as follows:

Each councilor shall be the judicial representative of this Society for his district consisting of certain counties. He shall visit the component societies in his dis-

trict at least once a year and make a report of such visit at the next meeting of the Board of Trustees and Councilors. It shall be his function to help organize component county medical societies where none exist; to inquire into the condition of the profession, and to improve and increase the zeal of component county medical societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. Members of the Board of Trustees and Councilors shall be reimbursed for their travel expenses in attendance at Board meetings, and for any official business of this Society.

The Board of Trustees of The Medical Society of the State of Pennsylvania, in support of a recommendation of a special committee to study the proposal for grievance committees in Pennsylvania, recommends to the 1950 House of Delegates the adoption of an amendment to Section 3 of Chapter IV of the By-laws by adding the words *or by the public* at the end of the fourth sentence.

Section 3 of Chapter IV would then read as follows (words in italics constitute the only amendment):

SECTION 3.—The district censors of each councilor district shall sit under the chairmanship of the councilor of the district who shall not have the right to vote. They shall consider every case of appeal from the decision of a component county medical society by a member who has been censured, suspended, or expelled, provided that the appeal is made within three months after the censure, suspension, or expulsion. They shall report in writing their decision thereon to the county medical society, and also to the trustees and councilors of this Society. They shall consider and dispose of all questions affecting the principles of medical ethics that may be referred to them, either by a component county medical society or by this Society *or by the public*. The decision of the censors in every case must be signed by a majority of the board. Any appeal or judicial question arising in a district comprised of less than three county societies shall be referred directly to the judicial council of this Society.

At the regular meeting of the Lancaster City and County Medical Society held on April 5, 1950, the following resolution was adopted:

Resolution

Be it resolved, That Chapter VII, Section 6, of the By-laws of The Medical Society of the State of Pennsylvania, which now reads:

The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of five members.

It shall be the duty of the committee, after careful consideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor of the House of Delegates. To conform to the requirements of the House of Delegates of the American Medical Association, each nominee must have been a Fellow of the American Medical Association for at least two years prior to his nomination.

be changed to read as follows (words in italics indicate amendment):

SECTION 6.—The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of *three members, one member to be elected by the House of Delegates each year to serve a term of three years. At the 1950 Session, the House of Delegates will elect three of its members to serve on this committee designating one of those elected to serve three years, one to serve two years, and one to serve one year. In case a vacancy occurs between sessions of the House of Delegates, the unexpired term of the member of the committee shall be filled by a special election of the House of Delegates held on the first day of the first session of the House of Delegates immediately following the time the vacancy occurs.*

It shall be the duty of the committee, after careful consideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor of the House of Delegates. To conform to the requirements of the House of Delegates of the American Medical Association, each nominee must have been a Fellow of the American Medical Association for at least two years prior to his nomination.

Among the general officers and others to be elected at this session will be:

A trustee and councilor for the Third Councilor District, to serve for five years, to succeed Dr. Francis J. Conahan, Bethlehem, who is completing his first term of five years.

A trustee and councilor for the Ninth Councilor District, to serve for five years, to succeed Dr. Frank A. Lorenzo, Punxsutawney, who is ineligible for re-election, having served two complete terms of five years each.

Five delegates and eleven alternates to the House of Delegates of the American Medical Association, to serve from Jan. 1, 1951, to Dec. 31, 1952.

REGISTER TO VOTE!

It is extremely important that doctors and all voting-age members of their families be registered. Please do not neglect your duty as a citizen.

FIGHT UNTRUTH WITH TRUTH

(SECRETARY-TREASURER'S NOTE: The only reason for printing the following story so familiar to doctors of medicine is the hope that it will stimulate JOURNAL readers to realize that the antivivisectionists still receive staunch support through the columns of certain newspapers throughout the United States. Each JOURNAL reader can do his part to minimize this pernicious influence by constantly bringing to the attention of his clientele and neighbors the dramatic story of human lives saved by the millions through humane experimentation on a comparatively few animals.)

An article entitled "War Grows on Vivisection Torture" occupied an entire page in the Sunday, March 5, Pittsburgh *Sun-Telegraph*.

Under the caption "Friends of Pets Oppose Cruelty" appear the following paragraphs: "Moving energetically to stop the senseless and shocking barbarity of vivisection, humane societies in a dozen states are forming a common front to counteract the pressure lobbies of animal experimenters and the commercial racket that supplies them with victims.

"Led by the American Antivivisection Society and the National Society Against Vivisection, coordinated action on a state and national level is being organized in Pennsylvania."

Such a statement together with the pictures accompanying the article would soften the heart of the most rabid criminal—all on an emotional foundation.

The article further states: "'Dog surrender' laws that make possible the illicit and infamous traffic in pets stolen or lured from homes for delivery to laboratories have been defeated in Illinois, Pennsylvania, Massachusetts, Oklahoma, and Washington, D. C."

Apparently the so-called "antivivisectionists" did not read the act introduced in the last session of the Pennsylvania Legislature which was drafted for the purpose of stopping "illicit and infamous traffic in pets."

Under this act no animal is considered unclaimed or unwanted unless it has been kept in a public pound for ten days, and under no circumstances less than five days.

If such a law were passed, there would be no occasion for anybody's pet to be stolen. Unclaimed and unwanted animals directed to licensed institutions would be killed in the gas chamber anyway.

The dictionary defines "vivisection" as "a dissection of or cutting operation upon a living animal."

The text of the article leads one to believe that all of the experiments for the purpose of determining the cause, treatment, and eradication of a disease are done without an anesthetic. This is

very readily assumed from the following statement: "Every imaginable trick or stunt of surgery is practiced upon them while living and breathing."

All institutions licensed by the Department of Health must conform to regulations requiring them to adhere to specific methods in order that animals are treated in a humane and sanitary manner.

The article assumes that vivisection damages the moral character of the experimenter and destroys in him the instincts of mercy.

This is an extremely bold statement and reflects on the moral character of every practicing doctor of medicine whose entire interest is the welfare of his patients. Very few physicians are of low moral character. Many are active in religious organizations and have a sincere understanding of religion and moral tenets.

The following statement tries to prove that vivisection is useless and needless: "From every practical humanitarian and moral point of view, therefore, vivisection is now fully exposed as useless, needless, dangerous, and completely unworthy of toleration in any civilized community.

"That is why it must be opposed, attacked, and finally forever exiled from our nation."

In the light of facts developed by proper scientific research, this is not true.

Outstanding results of experiments are many, a dozen of which are listed:

1. *Insulin* is now keeping one million Americans alive today, although suffering from diabetes, a disease that used to kill everyone it touched. Only a few dogs lost their lives before the substance was made pure enough to warrant its trial on human beings. In the production of life-saving insulin *today*, every new lot must continue to be tested on animals to be sure that the product is safe for the sick man, woman, and child.

2. *Antitetanus* serum is another life-saver. Many persons will remember when a rusty nail in the foot frequently meant death in the awful grip of tetanus, with neck contorted and jaws locked.

3. *Diphtheria antitoxin* is another preserver of life. Not long ago parents watched helplessly while their children tried to draw breath into throats clogged with diphtheria. Then diphtheria antitoxin was perfected.

4. *Blood plasma and blood transfusions*. These were discovered and made safe largely through experiments on dogs.

5. *Pernicious anemia*. The true cause was found and its control worked out through experimenting with liver therapy on anemic dogs.

6. *Rickets, scurvy, and pellagra*. All now have cures and preventive measures because of studies made on various animals.

7. *Diseases of the lungs*. Paralysis of the respiratory nerves used to mean certain death. Now we have the *iron lung*—at a cost of 24 cats.

8. *Blue babies* are now saved by the hundreds through an intricate new operation on the heart and arteries. The cost? 75 dogs! And, had the use of these dogs been unavailable, no doctor would have dared to try the operation on a human being!

9. A variety of *anesthetics* have been made available through experiments—without which nine-tenths of modern surgery would be impossible.

10. *Digestive and kidney disorders, glandular disturbances, and malaria* have all been better controlled as a result of scientific experiments on animals.

11. The drugs, such as the *sulfonamides* and *penicillin*, discovered by chemical experiments alone, would be of no earthly use if researchers had not been able to test them on animals. The animal is an essential factor in the testing of all powerful drugs and is required by our Federal Food, Drug and Cosmetic Acts. The following incident illustrates this value: Dr. Victor Heiser, well-known author, put the problem before a legislative hearing where a large number of anti-vivisectionists were present. Out of his pocket, Dr. Heiser pulled a bottle of medicine and said, "This contains a possible cure for hookworm, and ordinarily we would test it on a dog. Since you object to that, let's try another procedure." He then indicated one of the objectors and said, "I'll give you one teaspoonful," and to another he said, "I'll give you two," and to another, "I'll give you three. Then we'll see what happens. You will possibly become terribly sick, but I don't believe you will *die*. Anyway, you will have had the satisfaction of knowing that you have served your best friend, the dog." Dr. Heiser started pouring, and the three antivivisectionists were suddenly nowhere to be seen!

12. The *bronchoscope*—that priceless instrument that removes nails, bones, and safety pins lodged in throats and lungs—was perfected by the use of dogs. Thousands are alive today because of it. Bozo, a dachshund at Jefferson Medical College, has been used to train 26 specialists

to date. Bozo is in excellent health and recently was honored during "dog week" by the Dachshund Club of America, through its president, who presented a citation and a plaque of award to Bozo. In Great Britain, where antivivisection laws partially exist, there are *no* bronchoscopists and only the wealthy can take plane trips to the United States in order to save their lives!

C. L. PALMER, M.D.

DELAWARE COUNTY MEDICAL SOCIETY'S CENTENNIAL CELEBRATION

The Delaware County Medical Society celebrated its one hundredth birthday on June 8, 1950. Extensive plans were made to commemorate the event in a fitting manner. A history of the society was written by Dr. C. Irvin Stiteler, one of the society's oldest members, and will be published, together with other accounts of the celebration activities, in a special bulletin to be published in the fall. Feature articles were published in the county and Philadelphia newspapers prepared by a professional newspaper feature writer. A radio program was broadcast. Exhibits depicting the progress of medicine in the last one hundred years were displayed in drug store windows throughout the county through the cooperation of the Delaware County Pharmaceutical Association and instrument makers and pharmaceutical houses. The celebration was climaxed by a mammoth dinner meeting to which leaders of the medical, dental, pharmaceutical, and legal professions, prominent Pennsylvania political leaders, and Delaware County celebrities were invited. The Honorable Harold L. Ervin, president judge of the Delaware County courts, made the principal address of the evening. Entertainment was provided by the Curtis Institute of Music and the event ended with dancing to the music of an outstanding Philadelphia orchestra.

HONOR ROLL

As of June 19, a total of 10,110 members of The Medical Society of the State of Pennsylvania had paid their 1950 county and state society dues. Of this number, only 6.3 per cent failed to pay their 1950 AMA dues.

We append the alphabetical list of counties showing the number of active members and on a percentage basis the proportion of those who have paid and remain in good standing.

It will be noticed that only 5 of the 60 county societies are less than 90 per cent paid, while 37 societies are more than 95 per cent paid up.

It is this type of consistent unified support by individual members that maintains the high rating of The Medical Society of the State of Pennsylvania among the constituent associations of the American Medical Association.

County	<i>Active</i>		County	<i>Active</i>	
	<i>Mem-ber-ship</i>	<i>Per Cent Paid</i>		<i>Mem-ber-ship</i>	<i>Per Cent Paid</i>
Adams	26	100	Lackawanna	290	95
Allegheny .	1624	98	Lancaster ..	222	100
Armstrong .	44	97	Lawrence ..	80	99
Beaver	135	93	Lebanon ...	74	97
Bedford ...	15	78	Lehigh	227	98
Berks	255	98	Luzerne	383	95
Blair	125	92	Lycoming ..	146	90
Bradford ..	46	96	McKean ...	50	100
Bucks	92	92	Mercer	87	95
Butler	68	96	Mifflin	39	100
Cambria ...	164	94	Monroe ...	42	92
Carbon	37	100	Montgomery	348	95
Centre	36	97	Montour ...	38	100
Chester	125	92	Northampton	195	99
Clarion	22	100	Northumb'l'd	77	96
Clearfield ..	46	96	Perry	13	99
Clinton	28	100	Philadelphia	3199	93
Columbia ..	44	100	Potter	9	100
Crawford ..	55	98	Schuylkill .	156	93
Cumberland	49	96	Somerset ..	32	90
Dauphin ...	252	99	Susquehanna	16	99
Delaware ..	309	93	Tioga	26	88
Elk	27	81	Venango ...	52	92
Erie	202	99	Warren ...	47	99
Fayette	120	94	Washington	139	94
Franklin ...	82	96	Wayne-Pike	24	99
Greene	25	88	Westmore'l'd	213	96
Huntingdon	29	96	Wyoming ..	14	99
Indiana	42	99	York	171	97
Jefferson ..	62	92			
Juniata	7	99	Total ...	10,648	

RESOLUTION OF APPRECIATION

The following resolution was unanimously adopted April 29, 1950, by the Committee on Public Relations of The Medical Society of the State of Pennsylvania in appreciation of the services rendered by Dr. Howard K. Petry during his tenure of office as chairman of the Committee on Public Relations:

WHEREAS, Dr. Howard K. Petry, at his own request, has been relieved of the chairmanship of the Committee

on Public Relations of The Medical Society of the State of Pennsylvania, and

WHEREAS, Dr. Petry has served most capably in this very responsible position during the crucial years of 1947 to 1950, and

WHEREAS, His mature judgment, balancing overenthusiasm with needed conservatism, has aided much in the provision and organization of a forward-looking program of practical public relations for The Medical Society of the State of Pennsylvania and in the National Education Program of the American Medical Association, and

WHEREAS, Dr. Petry has given much of his time and his strength to the implementation of these programs, without thought of self or personal gain, but solely in the interest of the medical profession and the public at large;

Be it here resolved:

That members of the Committee on Public Relations of The Medical Society of the State of Pennsylvania, in regular meeting assembled, welcome the continued, active interest of Dr. Howard K. Petry as one of their number, and

That the members of this committee extend their whole-hearted thanks to Dr. Petry for his leadership and services as chairman of the committee from 1947 to 1950, and

That the members of the committee express their hope that his advice and wise counsel will long continue available.

Be it further resolved:

That a copy of this resolution be spread upon the minutes of this meeting of the Committee on Public Relations of The Medical Society of the State of Pennsylvania, and

That copies of this resolution be forwarded to Dr. Petry, to the president and to the secretary of The Medical Society of the State of Pennsylvania, and to the editor of THE PENNSYLVANIA MEDICAL JOURNAL.

COMMUNITY EMERGENCY MEDICAL CALL SERVICE

Continuing the series of reports on the above subject as read at the 1950 Secretaries-Editors Conference and printed in the May PENNSYLVANIA MEDICAL JOURNAL, we offer herewith three additional reports. Others will appear in the July issue.

Cambria County

Through the Physicians' and Dentists' Service Bureau, incorporated in September, 1938, as a non-profit central business organization, owned and operated by members of the Cambria County Medical and Dental Societies, Telephone Answering Service and an Emergency Medical Call System were inaugurated as an added service to the bureau and actual operation commenced Dec. 1, 1948.

Plans for this service were considered early in 1941.

However, war intervened and not until 1947 was there any possibility of securing the necessary equipment for operating this type of service in Johnstown. Contracts were completed with the local telephone company in the middle of 1947 and actual installation of a secretarial board was commenced in October, 1948, with service starting December 1.

A 100-line telephone secretarial board for direct line connection with subscribers' phones was installed along with three rotary trunk lines for incoming calls. The board is manned 24 hours per day by trained personnel who serve as telephone secretaries just as though they were the subscribers' own secretaries.

Three regular secretaries and one relief secretary take care of this service and handle all calls around the clock. The Emergency Medical Call system was set up through the public relations committee of the medical society and the physicians listed are called on a rotating basis as far as possible to carry out this plan, considering the area in the city from which the emergency call may have originated.

Publicity in regard to the Emergency Medical Call system was also set up and planned by the public relations committee of the society. Newspaper articles were written and appeared in local papers on Dec. 9, 1948. Prior articles had been written calling attention to plans being formulated by the society. Cards (4 $\frac{3}{4}$ " x 8 $\frac{3}{4}$ ") were printed with the following copy: "If You Cannot Locate Your Family Doctor in an Emergency—Call Telephone Answering Service 2-1213." These cards were mailed to all local medical and dental offices, to all police and fire headquarters in Johnstown and surrounding boroughs, to all drug stores and local eating places, and civic organizations such as the Y.M.C.A., Y.W.C.A., and so forth, throughout the city.

From December, 1948, to November, 1949 (a 12-month period), the Telephone Answering Service handled 433 emergency calls. December, 1949, and January, 1950, each had 48 emergency calls. At the present time 30 physicians have their names on the call service. However, the general practitioner is the one usually involved in emergency calls and 10 physicians have been handling these cases.

The Telephone Answering Service started in December, 1948, with 22 physicians using this service; it now includes 42 physicians out of a possible 85 practicing in the local downtown area of Johnstown. Three physicians use the "If No Answer Service," as direct line facilities are not available to these offices. The total number of calls handled by the telephone secretaries for the physicians using the service will average now between 2800 and 3600 exclusive of the calls necessary to dispatch messages back and forth between physicians' offices, patients, and hospitals.

The value of this service cannot be measured in dollars and cents, and there is no question but what it has been a definite factor in improving the good will of the general public towards the medical profession in Johnstown the past 14 months. The records show that there has not been one bit of adverse criticism, and one can get a doctor in ease of an emergency. Much is yet to be done and full cooperation is necessary by the entire medical profession to carry on this most important public relations work.

Dauphin County

The Dauphin County Medical Society, through the Medical Bureau of Harrisburg, was the first county in the State to operate an emergency medical call service under the direct control of the medical profession. In May, 1944, the Medical Bureau and the doctors of Dauphin County consolidated facilities and efforts to obviate the cry that "doctors cannot be reached on Thursdays, week-ends, or holidays."

The Medical Bureau operates three distinct methods of telephone service. The first consists of two secretarial stop-boards located in the bureau offices to which 114 doctors are assigned. Through this service, the doctor's office and residence phones are automatically covered when he or members of his family are not available. The calls are automatically diverted into the board where the operator answers the phone and assists the caller according to instructions from the doctor. The second method of operation pertains to the alternate listing service. Through this service the doctor inserts in the telephone directory, under his regular phone number, the telephone number of the Dauphin County Medical Society offices, which incidentally, is the same as the Medical Bureau number, instructing that calls be made to that number if there is no answer on his private line. The third operation is the Emergency Call Service. A panel of 14 physicians constitutes this roster and it is divided according to districts in the city and county. Here the operators at the bureau answer the emergency calls and obtain aid for the emergency. How these calls are handled is of primary importance, but time does not permit explanation. I shall be happy to answer any questions in regard to our operation during the question and answer period—such questions as: "How do you determine an emergency call? What do you do about chronic callers who make nuisances of themselves when no emergency exists? What do you do if a doctor refuses to make a call to his own patient? How do you stop dope addicts? Why is it not advisable to have a commercial exchange handle your emergency call service? What about miscarriage medical service, if they occur frequently? I believe our experience with these problems can and will help you in the efficient performance of your emergency medical call service."

AMERICAN MEDICAL ASSOCIATION COORDINATING COMMITTEE

To State and County Medical Societies:

This is to advise that at a meeting of the Board of Trustees and the Coordinating Committee on Sunday, May 28, a nation-wide advertising program covering newspapers, magazines, and radio was given final and unanimous approval.

After thorough consideration of all aspects involved, including the profession's position with Congress, it was concluded that the program presented by Whitaker & Baxter will solidify the real gains made in our campaign, advance the cause of voluntary health insurance, and emphasize to the public medicine's leadership in maintaining the American system and combating socialism.

The advertising program is scheduled for October. You will be advised by Whitaker & Baxter within the next three weeks of full details in respect to all three schedules.

This decision was reached after a thorough study of the facts and an all-day discussion. We are completely confident that medicine's objectives in this program will be successfully accomplished, and we shall deeply appreciate the whole-hearted support and cooperation of the state and county medical societies.

Sincerely,

ERNEST E. IRONS, M.D.,
President,

LOUIS H. BAUER, M.D.,
Chairman, Board of Trustees.

ELMER L. HENDERSON, M.D.,
Chairman, Coordinating Committee.

May 29, 1950

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since March 31. Figures in first column denote county society numbers; second column, State Society numbers.

Apr. 1	Northumberland	69-70	9267-9268	\$46.00
5	Cambria	147-148	9269-9270	46.00
6	Monroe	34-38	9271-9275	115.00
	Lackawanna	232-242,		
		244-246	9276-9289	322.00
	Wayne-Pike	24	9290	23.00
	Luzerne	339-344	9291-9296	138.00
	Somerset	27	9297	23.00
	Bucks	78-80	9298-9300	69.00
	Armstrong	41	9301	23.00
8	Lawrence	69	9302	23.00
	Jefferson	49-51	9303-9305	69.00
	Westmoreland	186-200	9306-9320	345.00
10	Lancaster	218-220	9321-9323	69.00
	Delaware	276-281	9324-9329	138.00
	Jefferson	52	9330	23.00
11	Washington	132	9331	23.00
	Northumberland	71	9332	23.00
	Blair	108-111	9333-9336	92.00
	Montgomery	261, 295,		
		282-285	9337-9342	138.00
12	Jefferson	53	9343	23.00
13	Lackawanna	243, 247-255	9344-9353	230.00
	Venango	44	9354	23.00
	Crawford	50-52	9355-9357	69.00
	Chester	112-113	9358-9359	46.00
14	Luzerne	345-350	9360-9365	138.00
	Fayette	105	9366	23.00
17	Lackawanna	256-257	9367-9368	46.00
	Lehigh	210-221	9369-9380	276.00
	Washington	133	9381	23.00
	Cambria	149	9382	23.00
	York	165	9383	23.00
	Fayette	106	9384	23.00
	Adams	26	9385	23.00
	Wyoming	13	9386	23.00
	Butler	61-62	9387-9388	46.00

Apr. 17 Delaware	282-286	9389-9393	\$115.00
Berks	240-244	9394-9398	115.00
Jefferson	54	9399	23.00
Huntingdon	28	9400	23.00
18 Mercer	80-81	9401-9402	46.00
Elk	19-22, 24	9403-9407	115.00
Montgomery	290-294,		
	296-301	9408-9418	253.00
21 McKean	47-48	9419-9420	46.00
Blair	112	9421	23.00
Allegheny	1465-1534	9422-9491	1,610.00
24 Franklin	77-80	9492-9495	92.00
Lancaster	221-223	9496-9498	69.00
Bucks	81	9499	23.00

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Franklin County	\$50.00
Woman's Auxiliary, Greene County	110.00
Woman's Auxiliary, Clearfield County	50.00
Dr. Thomas H. Low, in memory of Dr. Paul H. Kleinhans	5.00
Woman's Auxiliary, Potter County	9.00
Woman's Auxiliary, Delaware County Medical Club	25.00
Woman's Auxiliary, Mifflin County, honoring Dr. J. A. C. Clarkson	5.00
Woman's Auxiliary, Blair County	100.00
Woman's Auxiliary, Allegheny County	1,764.37
Woman's Auxiliary, Luzerne County	100.00
Woman's Auxiliary, Columbia County	26.00
Woman's Auxiliary, Berks County, a friend, in memory of Mrs. H. M. Frye and Dr. A. H. Bauscher	5.00
Dr. William A. Finady, Northampton County	100.00
Woman's Auxiliary, Philadelphia County	150.00
Woman's Auxiliary, Berks County	330.00
Woman's Auxiliary, Montgomery County, a friend, memorials	25.00
Total previously reported	2,766.85

Total contributions since 1949 report\$5,021.22

CHANGES IN MEMBERSHIP

New (38) and Reinstated (3) Members

ALLEGHENY COUNTY: Mary P. L. Bailey, Mary L. Black, Lawrence Greenman, Morton L. Hammond, Raymond J. Klavon, George S. Rectenwald, John A. Zelnik, Jr., and Charles W. Zimmerman, Pittsburgh; Stephen J. C. Miller, Tarentum.

BEAVER COUNTY: Embrie J. Borkovic, Beaver Falls.

BERKS COUNTY: Mary Paulosky, Reading.

BUTLER COUNTY: Ernest E. Moore, Butler.

DAUPHIN COUNTY: John B. Logan, Harrisburg; Frank F. Pierce, Hershey.

DELAWARE COUNTY: Samuel P. Ivins, Chester; Walter E. Kepler, Jr., Drexel Hill; Anna E. F. Ziegler, Upper Darby.

FRANKLIN COUNTY: John A. Hargleroad, H. Shipensburg; Renwick J. Runk, Jr., Chambersburg.

JEFFERSON COUNTY: William C. Vernocy, Punxsutawney.

LACKAWANNA COUNTY: Velio E. Berardis and William J. Lussy, Scranton; Vera Sorokonich, Old Forge; Vincent E. Wall, Jermyrn.

LANCASTER COUNTY: Elenor Jane Fleming, Landisville; Edgar D. Knerr, Jr., and Harold S. Sandhaus, Lancaster.

LAWRENCE COUNTY: Donald M. Burke, Pittsburgh.

LEHIGH COUNTY: Edward T. Schantz and Earl K. Sipes, Allentown.

MONTGOMERY COUNTY: Robert A. Buyers, Norristown.

NORTHAMPTON COUNTY: William C. Hemmerly, Bethlehem.

NORTHUMBERLAND COUNTY: (Reinstated) John H. Wentzel, Sunbury.

PHILADELPHIA COUNTY: Randal A. Boyer, Ardmore; Milton Graub, James D. Hardy, Truman G. Schnabel, Jr., and Edgar C. Smith, Philadelphia. (Reinstated) Rowland Ricketts, Merchantville, N. J.; Daniel M. Rosman, Philadelphia.

WAYNE-PIKE COUNTY: Karl R. Beutner, Greentown.

Resignations (21), Transfers (15), Deaths (13)

ALLEGHENY: *Resignations*—Charles A. Bock, Wexford; Donald A. Fusia, Jr., Sayre; Joseph A. Coyle and Julius E. Gross, Dublin, Ga.; Winfield C. John, West Virginia; C. Clark Leydie, Jr., Iowa City, Ia.; Murray Sims, Coral Gables, Fla.; Charles C. Moore, Jr., Sterrett E. Dietrich, Edwin R. Fisher, and Paul E. Gittings, Pittsburgh. *Death*—John D. Kistler, Pittsburgh (Hahn. Med. Coll. '09), April 21, aged 64.

ARMSTRONG: *Transfer*—Samuel V. King, Templeton, from Mercer County Society.

BEAVER: *Resignation*—Dorothy K. Coffey, Baden.

BERKS: *Transfer*—William A. Ehr Gott, Fairmont, W. Va., to West Virginia State Medical Society.

BLAIR: *Death*—Joseph D. Findley, Altoona (Univ. Pa. '00), March 30, aged 72.

BUCKS: *Resignation*—Norman L. Loux, Providence, R. I.

CLARION: *Death*—Charles V. Hepler, New Bethlehem (Univ. Pgh. '05), April 21, aged 68.

DAUPHIN: *Death*—John R. Plank, Steelton (Jeff. Med. Coll. '96), April 1, aged 82.

DELAWARE: *Transfer*—Robert L. Hall, Havertown, from Philadelphia County Society.

GREENE: *Transfers*—Daniel P. Greenlee, Waynesburg, from Allegheny County Society; Matthew B. Moore, Carmichaels, from Fayette County Society; Robert W. Leibold, Wheeling, W. Va., to Ohio County (W. Va.) Medical Society.

LACKAWANNA: *Death*—Albert J. Winebrake, Scranton (Jeff. Med. Coll. '99), April 4, aged 75.

LANCASTER: *Transfer*—Howard Shaub, Marietta, to Anne Arundel County (Md.) Medical Society. *Death*—John L. Atlee, Lancaster (Univ. Pa. '00), April 3, aged 74.

LEHIGH: *Death*—H. Cotter Boyle, Philadelphia (Temple Univ. '13), March 20, aged 62.

LUZERNE: *Deaths*—H. Ward Fisher, Wilkes-Barre (Hahn. Med. Coll. '11), March 14, aged 64; Stanley L. Freeman, Kingston (Univ. Pa. '10), February, aged 61.

MONROE: *Transfer*—Edward T. Horn, Tannersville, from Northampton County Society.

MONTGOMERY: *Resignations*—Rosalie Ging, Saratoga; Earle C. Jameson, Jr., Philadelphia; Ethel R. Hankele, Neshaminy. *Transfers*—Lawrence D. Vantilborg, Ft. Pierce, Fla., to St. Lucie County (Fla.) Medical Society; Anna T. Onorato, Lansdale, to Mercer County (N. J.) Medical Society.

NORTHAMPTON: *Resignation*—Charles R. DuGan, Pittsburgh. *Death*—Paul L. Kleinhans, Bethlehem (Univ. Pa. '12), April 4, aged 61.

PHILADELPHIA: *Resignations*—Vincent J. Cattie, H. Burton Lochhead, and Ephraim M. Rosset, Philadelphia; Abraham W. Danish, Washington, D. C.; M. Catherine Magee, New York City. *Transfers*—Harry P. Goodman, Atlantic City, N. J., to New Jersey State Society; George W. Burch, Tyler, Texas, to Texas State Society; Malcolm C. Spencer, Danville, Ill., to Illinois State Society; William S. Johnson, Lakeland, Fla., to Florida State Society. *Deaths*—Frank J. Briglia, Philadelphia (Jeff. Med. Coll. '28), April 5, aged 46; Robert A. Boyer, Philadelphia (Med.-Chi. Coll. '98), April 15, aged 73; John C. Siggins, Philadelphia (Univ. Pa. '01), March 29, aged 69.

WYOMING: *Transfer*—Albert L. Hunter, Laceyville, from Bradford County Society.

usage of this service, which proves that it has served our physicians well.

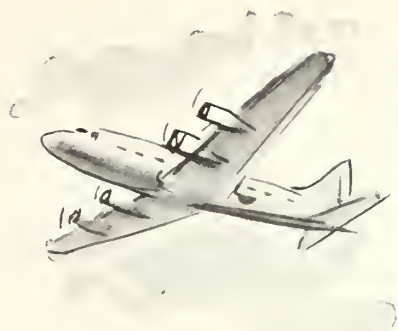
The following requests were filled during the month of April:

Treatment of dandruff	Nervous disorders
Thrombopenic purpura	Skin
Vascular system	Teeth
Sleep paralysis	Respiration
Infectious mononucleosis	Narcotics
Myanesis	Bronchiolitis
Treatment of common cold	Oxyuriasis
Cancer of the skin	Cholelithiasis
Chlorophyll	Tuberculous pericarditis
Bunionectomies	Myocardial infarction
Women in medicine	Modern dental anesthesia
Hepatorenal syndrome	Coronary occlusion
Addison's disease	Social hygiene
Eye exercises	Male climacteric
Medical group practice	Nutrition
Cardiospasm	Cancer research
Cold permanent waves	Socialized medicine
Tumor clinics	Atopic dermatitis
Hearing impairments	Silicosis
Surgery of the foot	Syphilis of the lung
Blood banks (2)	Glaucoma
Leukemia	Polycythemia
Serum tests for cancer	Women physicians
Antibiotics	Animal experimentation
Prenatal care	Child psychology
Music therapy (2)	Orthopedics
Mental health	Physical therapy
Reproduction	Occupational therapists
Endocrine glands	Breast feeding
Hearing clinics	
Acquired hemolytic anemia	
Clinical and social problems of epilepsy	
Diagnosis of arthritic diseases	
Blood derivatives and fractions	
Treatment of skin malignancy by irradiation	
Carcinoma of fallopian tubes	
Intermittent hydronephrosis	
Chronic carbon monoxide poisoning	
Drowning and resuscitation	
Estrogens and bone formation	
Treatment of fractures of facial bones	
Treatment of peptic ulcer	
Fluorine in water supplies	
Emotional problems of children	
Internships in the United States	
Sulfur dioxide and its effects	
Dislocation of the shoulder	
Huggins' test for cancer (2)	
History of dental anesthesia	
Pseudohypertrophic muscular dystrophy	
Diagnosis and treatment of illuminating gas poisoning	
Carbon monoxide poisoning	
Pellegrini-Stieda disease	
Postgraduate education courses	
Adenocarcinoma of the breast	
Magnesium in the treatment of dysmenorrhea	
Follicular lymphoblastoma	
Cleft palate and cleft lip	

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Do you have any puzzling diagnostic problems to solve or a paper to prepare for professional or lay audiences? If so, why not take advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? At the present time there are more than 104,000 reprints and tear sheets from various publications filed in the library for your use.

There has been a continuous increase in the



Airsickness, trainsickness, seasickness, carsickness—all respond to treatment with Dramamine (brand of dimenhydrinate.)

DRAMAMINE* —for the Prevention and Treatment of Motion Sickness. *Trademark of G. D. Searle & Co.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

AFTER many years of observation and careful experimentation, BCG vaccine is now being recommended in this country for use with certain population groups as a protection against tuberculosis. The Public Health Service is now ready to issue licenses for the production and distribution of BCG vaccine to physicians.

BCG VACCINATION

Calmette and Guerin

The initials BCG stand for *Bacillus of Calmette and Guerin*. It was named for the two French scientists who, using a potent bovine strain of tubercle bacillus isolated in 1902, were able to show a sharp reduction in virulence of the organism after repeated passage on an artificial medium. This finding led them to consider the possibility of further reducing the virulence of the strain in order to develop a living vaccine which by causing a mild and harmless infection would protect human beings against the invasion of more virulent organisms.

In 1908 Calmette and Guerin announced that they had developed a strain of bovine tubercle bacilli which had no virulence for cattle. Twelve years later, they reported that this BCG culture was harmless to man. Later studies of groups vaccinated with BCG confirmed this and showed a lowered illness rate and death rate for tuberculosis over varying periods of time in these groups.

This certainty, however, was not immediately reached. Lack of proper controls during the early work done with this vaccine, together with the difficulty of maintaining the fixed nonvirulent strain of the tubercle bacillus, retarded its widespread use. Over the years, the resistance to the use of BCG has been partially conquered, and it is now widely accepted as an effective tool when used in conjunction with other techniques of tuberculosis control.

Misunderstandings

Certain misconceptions about the use of BCG vaccine still persist. First of all, the vaccine is given only to those persons who are negative reactors to the tuberculin test. Over many centuries, the human race has become fairly resistant to tuberculosis. The majority of persons sooner or later become infected with tubercle bacilli and are positive reactors to the tuberculin test. They do not, however, in the vast majority of instances, become victims of real tuberculous disease. Although a certain immunity is gained through infection with the disease germ, a chance infection with virulent germs is not a satisfactory method of immunization. An infection with a mild and harmless strain of tubercle bacilli can be overcome by protective antibodies which may, in time, combat a future invasion of virulent germs. BCG vaccine is designed to strengthen resistance and thereby protect against a disease that might otherwise be disabling or fatal.

Groups to Be Vaccinated

Public health authorities consider it wise to confine BCG vaccination to groups such as nurses, medical students, and hospital personnel who are occupationally exposed to tuberculosis and to those who will be in direct contact with a person who has an open case of tuberculosis.

Vaccination is not undertaken when general weakness, minor infections, measles, whooping

cough, eczema, or furunculosis are encountered. BCG vaccination is not combined with vaccinations against other infectious diseases such as smallpox, diphtheria, typhoid fever, or tetanus.

BCG Is No Cure

BCG is a preventive measure, not a cure or a method of treating tuberculosis, and is used always as an adjunct to other methods of controlling the disease. Finding cases, isolating and treating them, rehabilitating and returning them to normal lives, are the principal methods of fighting this disease. BCG can reduce the number of persons who will become tuberculous, but it can in no way assist in fighting the disease after it has been contracted.

Duration of Protection

At the present time it is not possible to say that BCG provides immunity over any definite number of years. Research will doubtless provide us with reassuring answers in the future.

How Vaccination Is Done

BCG vaccination should be done only by those physicians who have observed the technique. Four methods of administering BCG vaccine are in use.

Birkhaug's Method

Birkhaug's method employs a spring-actuated 38 needle instrument that performs a multiple puncture vaccination with one downward action. A 4 x 4 centimeter piece of sterilized thin paper or cellophane is moistened on both sides with BCG vaccine and placed on the ether-cleansed skin. The skin is held taut. The head plate is evenly pressed against the paper, and the trigger is pushed. The needle points become coated with the vaccine as they perforate the paper and enter the skin.

Rosenthal's Method

With Rosenthal's method, the physician draws the required quantity of vaccine into a syringe with a 19-gauge needle. The skin is kept taut and three or four drops of vaccine are placed

over the ether-cleansed area of the arm or thigh and spread evenly with the side of the needle over a small area. Twenty to forty pressure punctures in four or five rows about a half centimeter apart are then made, and the vaccine is rubbed gently over the punctured area with the side of the needle.

Scarification

When the scarification method is used, the ether-cleansed area of the skin is not punctured, but three or four short linear scarifications are made across the drops of the vaccine either with syringe needle or a sewing needle. While the skin is held taut, the vaccine is rubbed gently over the area with the side of the needle. This method is not recommended by the New York State Department of Health.

Injection

The intracutaneous method requires vaccine which contains 1.0 milligram of micro-organisms per milliliter instead of 20 milligrams as used in other methods of vaccination. The outer surface of the left upper arm or thigh is cleansed with ether or alcohol, the skin is held taut and 0.1 cc. of the vaccine is injected between the layers of the skin using a tuberculin syringe with a fine needle.

BCG Only One Tool in Tuberculosis Control

When carefully carried out by experienced physicians, BCG vaccination causes no untoward reaction and promises to protect individuals against tuberculosis. When used as a part of the general tuberculosis control program, BCG provides us with one more means of attack on an age-old disease enemy of mankind. In the war-devastated countries of Europe, the World Health Organization is pushing forward a mass vaccination, the results of which may prolong the productive lives of many persons who, without such protection, would fall victim to tuberculosis.

BCG Vaccination, Howard C. Stewart, M.D., New York State Department of Health, Health News, December, 1949.



PHONE 117

GOSHEN "INTERPINES" NEW YORK

SPECIALIZING IN NEUROPSYCHIATRIC DISORDERS

ETHICAL—RELIABLE—SCIENTIFIC—QUIET—HOMELIKE

Frederick W. Seward, M.D., Director

Clarence A. Potter, M.D., Resident Physician

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Education

Considerable progress has been made throughout the Commonwealth during the past year in providing cancer education for the public and for practicing physicians. This was brought out in a report recently prepared by the Pennsylvania Cancer Coordinating Committee.

Professional Education

The American Cancer Society is sponsoring the production of six films in color on the early diagnosis of cancer for the practicing physician, medical students, nurses, and public health officials. Monographs written by leading clinicians designed for easy reference and quick review of most important diagnostic symptoms and signs in detecting early cancer by the busy doctor are being sponsored by the American Cancer Society. In the Pennsylvania Division, 6131 physicians are receiving these cancer brochures on the early recognition of cancer.

Fellowships in clinical cancer and exfoliative cytology are being offered to physicians upon application to the American Cancer Society, which also sponsors medical meetings and symposiums on cancer. More than 50 professional films related to cancer currently are available for loan to professional groups by the society. Pamphlets of factual material have been prepared by the society and are offered to members of the medical profession upon request.

The regional postgraduate institutes of The Medical Society of the State of Pennsylvania now include several talks on various phases of cancer which are of importance to the man in general practice. The Cancer Commission has arranged this type of educational program in conjunction with the Postgraduate Education Committee. The postgraduate refresher courses on cancer conducted at the University of Pennsylvania Medical School have thus far been attended by 84 physicians from 25 different counties of the State. These courses are for two weeks and are financed from funds from the Cancer Division of the State Department of Health. Dentists have had similar two weeks' courses at the University of Pittsburgh and thus far 39 dentists from 18 counties have taken advantage of this particular postgraduate training.

In commenting on this phase of the cancer program, which cost about \$23,000 last year, the committee report said:

"Great strides have been made in this state in professional education, particularly physicians. If the doctor wishes to learn modern cancer

management, there is plenty of opportunity. The planned undergraduate education in oncology will require greater financial commitment than has been made available. By vigorously supporting this effort, the profession can adopt a positive approach to a medical problem."

Adult Education

The committee reviewed with interest the adult educational program and the many different approaches being used to take the cancer education message before the public—through publications, pamphlets, news stories, talks, films, exhibitions, etc. On this part of the program, which cost about \$145,000, the committee commented:

"In the adult education program, many diverse approaches are being used to bring the message of early suspicion of cancer to the public. It is time to consider a survey appraisal of the value of the program in a metropolitan area, in a small town, and in a rural area. A committee is to be appointed by the chairman to investigate the advisability of a survey, and if such a survey is to be conducted, what particular points are to be surveyed.

"School education in cancer thus far has been incompletely developed, with many high school and particularly college groups considering health education an elective rather than a required study. It is recommended that cancer education be a required subject in the secondary schools insofar as possible."

Research

Commenting on research, the committee report said:

"The research program elsewhere in the State—other than the \$263,990 that the national office of the American Cancer Society returned to Philadelphia institutions in the form of fundamental research grants and fellowships—fed by funds from government and private sources, has no doubt been greatly augmented by the opening of the Institute for Cancer Research at Fox Chase. Monies made available each biennium by the Legislature specifically for cancer research should be assigned to acceptable projects. Perhaps the commission through its research committee could lend greater encouragement to teaching institutions and hospitals in the development of such. Virtually all the research money contributed to the Pennsylvania Division of the American Cancer Society goes outside the Division. Stimulation of studies within this area is desirable."

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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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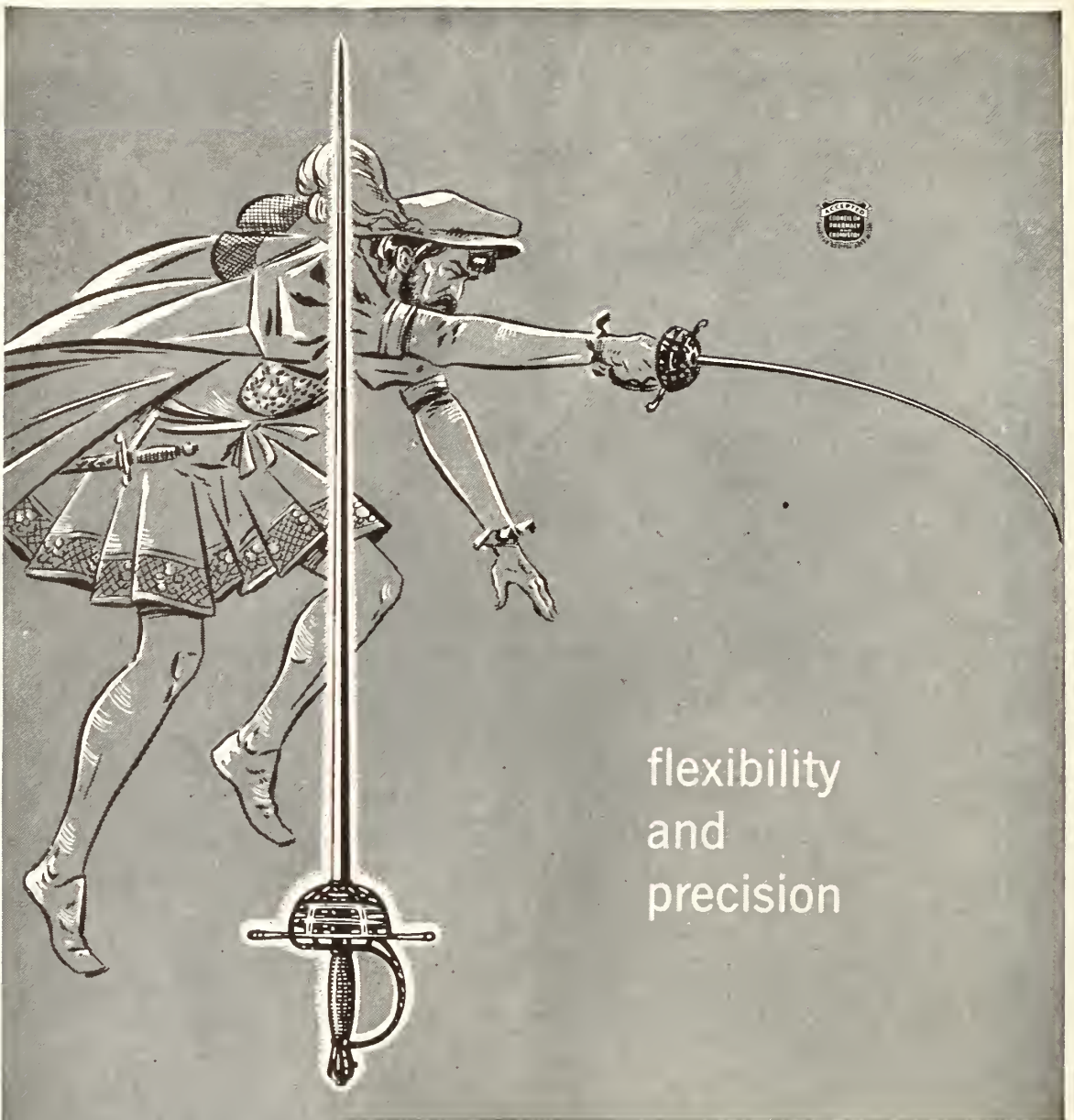


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547 Water Street, Indiana

THE 1950 AMA NATIONAL EDUCATIONAL CAMPAIGN

FRANCIS F. BORZELL, M.D.

Philadelphia, Pa.

"If we could first know where we are and whither we are tending, we could better judge what to do, and how to do it."

These are not my words but the words of the immortal Abraham Lincoln. He was moved to these words of wisdom in those dark days just preceding the Civil War. History truly repeats itself. We are once more threatened with a revolution as devastating in its potentialities as ever threatened our land. America today is on the verge of an Armageddon. We have come to a crossroad. There are those in high office and powerful position who would have us take a road to the left, a road called the Welfare State. This is the road of Fabian socialism. It leads to but one end—totalitarianism and Communism. The alarming thing is that the masses of America today do not see the ominous clouds already on the horizon. I am reminded of a quotation from the Gospel of Matthew:

"For as in the days that were before the flood, they were eating and drinking, marrying and giving in marriage, until the day that Noah entered into the Ark.

"And knew not until the flood came and took them all away."

True it is that the American doctor and the AMA and its constituent societies have until now succeeded in preventing the socialization of medicine here, and no small part has been played by you women and your organization.

It is also sadly true that while we are fighting to prevent the socialization of medicine by way of direct federal legislation for compulsory health insurance, we are to this extent defending the liberties of Americanism against the enslavement of socialism. Thus far we have succeeded, but

the irony of it all is that too many of our people are as unconscious of the threat as were the people before the deluge.

I wish I could present a happier picture than I have thus far, but unless we in the words of Lincoln know where we are and whither we are tending, we are lost.

You may ask what has all this harangue about socialism got to do with the AMA. Educational Campaign? Friends, it is the crux of the whole situation. We have been successful thus far, it is true, in preventing the passage of the Wagner-Murray-Dingell Bill, but these battles have only been skirmishes; we need to strengthen our forces for a decisive battle if American liberties are to be preserved.

If there has ever been any doubt, and there has been, as to the need or usefulness of a Woman's Auxiliary to the AMA, it has been completely dispelled in the past few years, particularly in the last year. It would indeed be a pleasurable task to recount to you the effectiveness of your activities in the last year alone, but pleasant as that would be, I must resist the temptation. In other words, where do we go from here?

There has been no armistice declared by the enemy. They are still strong. Their most dangerous tactics are insidious. Subversive elements are still at work. Mr. Oscar Ewing and his associates seem to have withdrawn from their complete support of the Wagner-Murray-Dingell Bill. Mr. Ewing has said that we must make some modification. Mr. Humphries, another sponsor, said the same thing. In a Washington Newsletter dated February 23, Senator Myers says, "Voluntary health plans should be encouraged in every way." This statement is in contrast to the administration's efforts to discredit voluntary methods.

They all found that their propaganda machine had not yet sufficiently softened the opposition of those who would preserve American liberties and traditions. Now we are faced with the dangers of flank attacks and still more propaganda.

Presented at the fourth annual conference of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania in Harrisburg, March 9, 1950.



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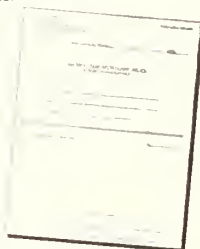
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Here are some of the conditions we find today:

1. The U. S. Department of Justice is using the FBI to illegally investigate the AMA and twenty odd state and county medical societies. The purpose of this investigation is obviously intended to harass and adversely affect the popular attitude toward doctors and the AMA.

2. There is hardly a medical school in the country which does not have a Communist cell within its walls. They are nationally organized under the name of the Association of Interns and Medical Students. They are commonly called the AIMS. Every medical school in Philadelphia has a chapter of the AIMS, except one. At a World Youth Assembly under Moscow direction held at Budapest, Hungary, last summer, there were 200 American youths as delegates. Of these, 13 were from the AIMS. The chairman was an intern from a New York hospital.

3. The American Public Health Association is strongly supporting compulsory health insurance, according to a recent report of a subcommittee of the APHA.

4. Legislation is pending in Washington which, if passed, will drive us a long way forward on the road to Socialism. Bills S. 1411, S. 1453, and H. R. 6000 are examples.

5. This is the most dangerous situation of all. Too many of our otherwise best legislators are wavering and are becoming foggy in their thinking. They have adopted a policy of me-too-ism. There are too many non-medical groups unaware that our fight is their fight for liberty.

This is my view of where we are and whither we are tending. Now, what are we to do, and how are we to do it? This is the purpose of our 1950 Educational Campaign. If there is one thing that stands out more prominently than any other, it is that the fight must be brought down to a local level. In fact, if we are to be successful, we must mobilize the infantry. This battle will not be won or lost on a national front. It will be at the grass roots. The activities and programs of Whitaker and Baxter and the House of Delegates and the Board of Trustees of the AMA on a national level must be implemented by your efforts and mine in our own communities.

To be more specific than I have been up to this moment, what is the program for 1950? I'll try to epitomize it as follows:

There are essentially two fronts. One may be characterized as defensive and the other offen-



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sive or, what may be more euphonious, one activity is of a negative character and the other positive.

The negative or defensive phase includes those activities necessary to prevent adverse legislation. The positive phase includes those programs necessary to meet the real medical needs of the people in answer to the charges used as arguments for the adverse legislation. On the positive side we must educate the people to the fact that economic problems can be met without sacrificing our liberties. They must also learn that legislation cannot take the place of personal responsibility, nor can government regulations take the place of fundamental principles.

The defensive or negative activities resolve themselves into rather well-defined areas of operation. We must maintain an alert organization that is "riding herd" on federal legislation. This the AMA is doing. It has just recently enlarged both the physical quarters and the personnel of its Washington office. Every piece of legislation is rigidly scrutinized, particularly for fringe implications. A legislative coordinating committee has been appointed to examine every piece of legislation proposed and watches its progress for amendments, etc. It is this committee's function, in close cooperation with Dr. Joseph S. Lawrence and his staff, to keep the profession constantly informed on legislation. We are prepared at almost a moment's notice to have the position of organized medicine expressed at legislative hearings. State and county societies are alerted to action and contact with key legislators in their home bailiwicks.

Key men in the national, state, and county societies are regularly kept informed by releases from the Washington office as to the status of legislation. It then becomes the duty of these men to inform their local groups.

Another phase of the defensive program is the solicitation of effective support from non-medical groups. The Woman's Auxiliary has had a large part in securing endorsements of our opposition to compulsory sickness insurance from thousands of organizations over the country. The work must go on and you can do it.

Active speakers' bureaus must be maintained, literature distributed, etc. In all these activities their effectiveness is in direct proportion to the degree of activity at the local (county) level.

As for the positive program, it is apparent in the minds of our campaign leaders, the coordinating committee, and the AMA Board of

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I have intentionally not spoken of any political activities until this moment. We are, of course, vitally interested in having legislators elected who believe in basic American liberties and who act accordingly. As individuals each of us can work as actively as he pleases in support of or in opposition to any candidate, but it is illegal for any corporation to engage in political activity. This prevents most county and state societies and the AMA from officially organizing specific political activities. This must be done by individuals. However, we can and should exert every effort to get citizens to vote.

The Woman's Auxiliary of Pennsylvania has been and still is in the forefront both locally and on the national level. However, there is still room for improvement. There are spots in our state where the men have not yet awakened to your value and importance. I fear there are men at the national level who are still lukewarm to your potentialities. This problem could consume hours in discussion. In fact, it should be the subject of serious consideration by the medical societies at all levels.

You who are the representatives of the woman's auxiliaries of Pennsylvania need no stimulation. Your works speak for themselves, but nationally we have not begun to tap the strength inherent in the women of our profession. You believe in liberty, you are willing to fight for it. We must all carry forward the slogan that we are fighting not for the four freedoms but for something much more precious—liberty.

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WHEELS TURNING

The wheels of auxiliary progress are turning constantly. Thirteen counties are sharing reports of their activities with our readers.

BERKS—In January four members of this auxiliary, Mrs. Paul C. Craig, Mrs. William H. Keffer, Mrs. Fred B. Nugent, and Mrs. Philip L. Rettew, presented a panel discussion on compulsory health insurance before the Robesonia Woman's Club. More than one hundred people were present and the meeting was a big success.

For contributions to the benevolence and building funds, aprons were passed around to the members, each of whom was asked to sew into one little pocket whatever she felt she wished to contribute.

An open meeting was held in February, at which time the speakers were Mrs. Paul C. Craig, chairman of the public relations committee of the Woman's Auxiliary to the AMA, and Mr. Sherwood Young, district manager of the Medical Service Association of Pennsylvania.

On March 13 at the meeting in the home of Mrs. Clair G. Spangler, Mrs. Herman F. Kotzen gave an account of the annual Mid-Year Conference in Harrisburg. The guest speaker for the afternoon was Miss Emmalyn Weiss, county supervisor of special education, who spoke about "The Education of the Exceptional Child."

Questionnaires have been sent to all members for their evaluation of auxiliary meetings, business, and

purpose. The auxiliary has purchased addressograph plates for the entire membership.

At the April meeting 16 new members who had joined the auxiliary since September, 1949, were welcomed officially. Mrs. Drury Hinton, president of the State Auxiliary, spoke on "The Auxiliary Approach to Medical Research."

CLINTON—A health poster contest is being held in this county. Letters have been written to senators and congressmen opposing socialized medicine. The annual rummage sale was held in April. The paid membership totals 21.

DAUPHIN—A benefit fashion show and tea was held on February 14 in the Civic Club of Harrisburg. Proceeds will augment the nurses' scholarship funds of the Harrisburg Hospital and the Harrisburg Polyclinic Hospital. Music was presented by a string trio composed of Mrs. Robert Clippinger, Miss Margaret Schmidt, and Mrs. John D. Walmer, a member of the auxiliary.

DELAWARE—A Valentine luncheon meeting was held at the Inglenook Tea Room in Swarthmore, at which time Mrs. Jane Heist, advisor on skin care, demonstrated cosmetics.

ERIE—At the February meeting in the home of Dr. and Mrs. Edward P. Dennis, Mrs. Herman W. Riester presented a program of current events. Mr. Clare Swisher, columnist, gave a "Press-cription for the Doctor's Wife" at a luncheon meeting March 6 at the Summit Hotel, Erie.

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FAYETTE—In February \$150 was given to the medical benevolence fund. Mrs. Anthony W. Moats, Jr., reported a total of 56 subscriptions to *Today's Health*. Mrs. Harry Staman discussed the National Health Act. A bake sale raised money for the May meeting, at which time new officers will be installed and past presidents honored.

The March meeting was held in the home of Mrs. David F. Sennett, who had previously distributed 32 "Keep Politics Out of This Picture" posters to various grocery stores. The ways and means committee sponsored a raffle, the prize a Hamilton automatic clothes dryer, in order to raise money for the first nurse's scholarship. The guest speaker at this meeting was Miss Patricia Locke, who spoke on her collection of spoons.

Mrs. Thomas G. McLellan entertained the auxiliary

in her home on April 6. The Rose Staman Scholarship, in memory of a deceased member, will be given to a student nurse this year. Mrs. Charles H. Smith was chosen the first honorary member. Solos by Mrs. W. W. Bobo, soprano, and Mrs. Pasquale Gigliotti, pianist, concluded the program.

INDIANA—The February meeting was held at the home of Mrs. Ralph G. Ellis. A contribution of \$10 will be given to the medical benevolence fund in memory of any member of the auxiliary or medical society upon the death of same. At this time a contribution was given in memory of Clark M. Smith, M.D. Mrs. William A. Simpson gave a very interesting talk on her recent European trip.

At the March meeting in the home of Mrs. George C. Martin, Mrs. Daniel H. Bee gave a report on the Mid-Year Conference held in Harrisburg. In April the

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medical society and auxiliary sponsored a public health meeting. Gilmore Sanes, M.D., chest surgeon, and Frances O'Neil, internist, both of Pittsburgh, spoke on "Tuberculosis."

LACKAWANNA—A buffet supper was held March 14 at the Hotel Jernyn, Scranton, at which time Mrs. Elizabeth Hill Conrad gave a book review of *One on the House* by Mary Lassatei. At a spring luncheon meeting April 11, J. William White, M.D., president of the Lackawanna County Chapter, American Cancer Society, spoke on "Radium Treatment of Cancer," and Mr. Walter Stoeckel spoke on "Gems and Their Care."

LEBANON—The first annual fashion show and card party was held in the Masonic Hall, Lebanon, in February. This was in support of the auxiliary's project of furnishing hospital beds for private homes, through the Visiting Nurses' Association. One bed has already been

purchased and more are needed. Mrs. Benedict H. Birkel served as fashion commentator.

At the March luncheon meeting at the Hotel Weimer, Lebanon, Mrs. Herbert C. McClelland reported on the Mid-Year Conference in Harrisburg, and Mrs. Charles E. Gardiner talked on "The Life of Henry William Stiegel." She exhibited a portion of Dr. Richard D. Schreiber's Stiegel glass collection. The health poster contest sponsored by the auxiliary had 275 entries from students in the city, county, and parochial schools. These were displayed in the Eagles' Auditorium on March 24.

LEHIGH—The medical society entertained the auxiliary at the annual banquet on January 13. Speakers included E. Roger Samuel, M.D., president of the MSSP, guest of honor, Rowland W. Bachman, M.D., outgoing president, and Martin S. Kleckner, M.D., incoming president. A music hour and buffet supper was held Sunday afternoon, January 23, at the Woman's Club, Allentown. The musical program included numbers by the Haff string ensemble, a vocal quartet of members of the county medical society, a vocal sextet of members of the woman's auxiliary, and individuals. The ensemble used instruments from the famous and valuable collection of the late Charles A. Haff, M.D., of Northampton, father of Donald W. Haff, M.D. Proceeds from the affair will be used for the auxiliary's welfare work.

The annual charity dessert-bridge party was held February 14 at the Woman's Club, Allentown. A bake sale was held in conjunction with the card party. Proceeds from the bake sale will be used for the nurses' fellowship fund and proceeds from the card party will be used for the medical benevolence fund.

On March 14 the auxiliary met at the home of Dr.

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GYNECOLOGY—Intensive Course, two weeks, starting June 19, September 25. Vaginal Approach to Pelvic Surgery, one week, starting September 18.

OBSTETRICS—Intensive Course, two weeks, starting September 11.

MEDICINE—Intensive General Course, two weeks, starting October 2. Electrocardiography and Heart Disease, two weeks, starting July 17. Gastroscopy, two weeks, starting July 17, September 25.

DERMATOLOGY—Formal Course, two weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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and Mrs. Donald W. Haff in Northampton. Ten dollars was contributed to the Red Cross and five dollars to the Crippled Children's Society. Three hundred pounds of drug samples and supplies were sent to New York to the Medical and Surgical Relief Committee. Eight members were in attendance at the Mid-Year Conference. The program feature of this meeting was Mrs. Forrest G. Schaeffer's review of Mika Walteri's novel, *The Egyptian*.

At the annual health program and reciprocity tea, April 11, Miss Anna Voelker, director of the Lehigh County Public Health Nursing Association, spoke on "The Work That Comes Out of 1115 Walnut Street." A donation was made to the Cancer Fund.

NORTHAMPTON—The annual membership tea was held at the home of Dr. and Mrs. Joseph N. Corriere, Bethlehem, on February 8. Mrs. J. Frederic Dreyer of Allentown, first vice-president of the State Auxiliary, was the guest speaker.

The March meeting was held at Hotel Easton, Easton. Mrs. Glenn Brogg, of Easton, read three original poems and Silva Laubach, 5-year-old daughter of Dr. and Mrs. George B. Laubach, sang and recited several selections.

NORTHUMBERLAND—The auxiliary is interested in the radio programs sponsored by the educational committee of the county medical society and heard over station WISL, Shamokin.

PHILADELPHIA—The February meeting was held at the County Medical Society Building in Philadelphia. One thousand dollars was donated to the Philadelphia Aid Association, \$300 was granted to another nursing scholarship, and a token donation was sent to the Philadelphia Y. W. C. A. Building Fund. A check for \$300 had been received from the county medical society for a nursing scholarship.

Mrs. J. Warren Hundley gave a talk on medical legislative problems. Mr. Horace Stewart spoke in behalf of the coming Red Cross campaign.

Mrs. Ralph W. Mays, chairman of the nursing scholarship committee, gave the following report: Miss Nancy White, recipient of one of the scholarships granted this year, was capped at exercises held at Frankford Hospital on February 22; Miss Anita Goff, the other scholarship recipient, was capped at the Jefferson Hospital on February 23. Both girls have done creditable work in the pre-clinical training period.

Mary Symington Geston, actress, teacher, and writer, was the guest speaker for the meeting.

The twenty-fifth anniversary was celebrated in March and the past presidents were honored. Mrs. M. Fraser Percival gave an interesting and informative talk on the 25 years of the auxiliary's existence. The Matinee Musical Sextet presented "Music of the Victorian Era." At the business meeting \$150 was given to the state benevolence fund, and token donations were sent to the Red Cross and the Cancer Crusade.

SCHUYLKILL—A luncheon meeting was held at the Necho Allen Hotel, Pottsville, in March. Corsages were presented to Mrs. George O. O. Santee, Cressona, and Mrs. John J. Moore, Pottsville, who organized the auxiliary in 1934. Mrs. Joseph C. Koch reported on the Mid-Year Conference. A memorial contribution to the state benevolence fund was made in memory of Mrs. Henry Dirschedl and Mrs. William H. Walters. The auxiliary plans to sponsor a nurse, the cost of her training to be paid over a period of three years.

The April meeting was held at the Pottsville Hospital. Mr. James Kirk, administrator of the hospital, showed a motion picture entitled "The White Battalion," giving an authentic reproduction of the behind-scenes activities in a modern hospital.

The auxiliary is sponsoring a course in ballroom dancing and social etiquette by Robert Kent of the Fred Astaire Studios; classes began April 24. The auxiliary has 400 names on file for use in legislative work against socialized medicine. Mrs. J. William Jones, president, has made six addresses before various groups on socialized medicine, and Mrs. Joseph C. Koch has spoken once.

MAKING HEALTH VISIBLE

The Medical Society of the State of Pennsylvania maintains a library of 16 mm. sound films on health subjects suitable for lay audiences which are available, on loan, to county medical societies, individual physicians, hospitals, service and women's clubs, schools, and other groups. There is no charge for these films other than the cost of return postage and insurance. Requests for films should be addressed to the Committee on Public Relations, The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa. Catalogs will be sent on request.

Thirty-two films, loaned by the Film Library, were used in ninety-seven showings during the month of April. They were:

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A Criminal Is Born

High school health classes, New Bloomfield
PTA meeting, Mansfield High School

A Question in Time

Cancer Clinic, Sacred Heart Hospital, Allentown

Be Your Age

Student nurses, State Hospital, Scranton
Fire Company Auxiliary, Blain
Olmsted Air Force Base, Middletown (2 showings)

Boy in Court

PTA meeting, Mansfield High School

Breast Cancer—The Problem of Early Diagnosis

Graduate Education Institute, Williamsport
Medical and nursing staffs, Pottsville Hospital
Staff doctors, Chester County Hospital, West Chester

Cancer—The Problem of Early Diagnosis

Hospital staff, Taylor
Student nurses, Harrisburg Hospital

Defense Against Invasion

High school assembly, Carlisle
Glenwood and Crouse Schools, Harrisburg
Hygienic School, Steelton
Forster Street YMCA, Harrisburg
4 H Clubs, Montour County (4 showings)

Enemy X

Student nurses, State Hospital, Scranton

Eyes for Tomorrow

Junior-senior high school health classes, Palmerton

Feeling of Rejection

High School, North Wales
Jackson PTA, Allentown
Stone Bridge Rotary Club, Susquehanna
Adult education class, Scott Township High School, Montdale
Rotary Club, New Milford

Human Growth

Church groups, Harrisburg
Lions Club, Highspire
High school faculty members, Highspire
Central Council of the PTA, Bethelchem
Liberty School PTA, Easton

Human Heart

High school health classes, Seneca
Student nurses, State Hospital, Scranton

In Daily Battle

High school health classes, Seneca

Life with Baby

Mount Pocono School

Man's Greatest Friend

Mount Pocono School
Sociology classes, senior high school, Lewistown

Woman's auxiliary to county medical society, Ridgway
Woman's Club, Bellefonte
East Pikeland Consolidated School, Phoenixville

Men of Medicine

Lewistown High School

Miracle Money

Student nurses, State Hospital, Scranton

Modern Guide to Health

Schools in Northumberland County (8 showings)

Modern Surgery

Mount Pocono School

New Frontiers of Medicine

PTA meeting, Millersburg

One Against the World

Lewistown High School

Seventh Column

Girl Scout Leaders' Club, Johnstown

Story of Dr. Jenner

Lewistown High School

Story of Menstruation

Liberty School PTA, Easton
PTA, Shoemaker Elementary School, Elkins Park
Church group, Harrisburg
Health classes, Millersburg
Health classes, Halifax
Health classes, Elizabethtown

They Live Again

Sociology class, senior high school, Lewistown
East Pikeland Consolidated School, Phoenixville
Woman's Club, Bellefonte
Woman's auxiliary to county medical society, Ridgway

Traitor Within

Olmsted Air Force Base, Middletown (5 showings)

Vim, Vigor and Vitamins

Girl Scout Leaders' Club, Johnstown
4 H Clubs, Montour County (3 showings)

What Is Cancer

Wilkes-Barre General Hospital
Nesbitt Memorial Hospital, Wilkes-Barre
Mercy Hospital, Wilkes-Barre
Hospital staff, Taylor

You, Time and Cancer

Cancer Clinic, Sacred Heart Hospital, Allentown

Your Ears

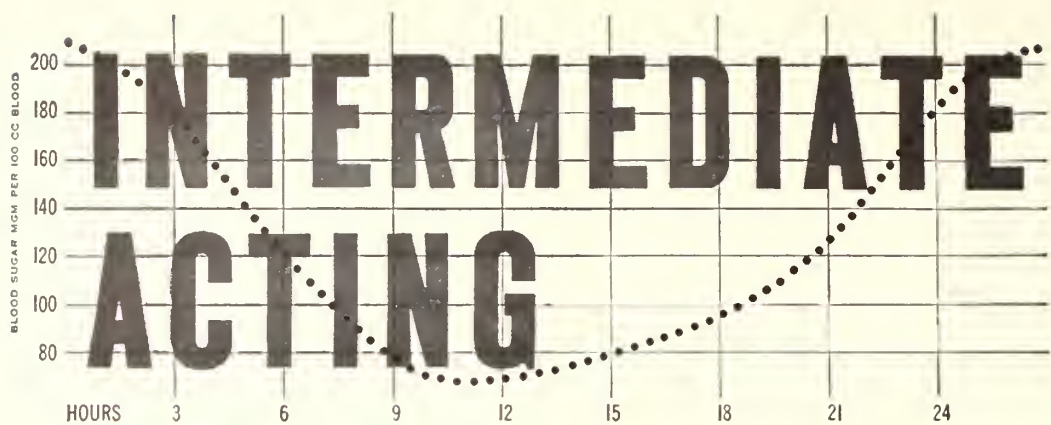
4 H Clubs, Montour County (3 showings)
Schools in Northumberland County (3 showings)

Your Eyes

4 H Clubs, Montour County (6 showings)
Schools in Northumberland County (3 showings)

An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.—Section 6, Chapter I, Principles of Medical Ethics of the American Medical Association.



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1. Rohr, J.H., and Colwell, A.R.: Arch. Int. Med. 82:54, 1948.
2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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MEDICAL NEWS

Births

TO DR. AND MRS. LLOYD S. PERSUN, JR., of Harrisburg, a son, April 13.

TO DR. AND MRS. FRANCIS J. BONNER, of Ardmore, a son, Dennis James Bonner, April 29.

TO DR. AND MRS. EDWARD J. CANNON, of Philadelphia, a daughter, Eva Agnes Cannon, May 13.

TO DR. AND MRS. JOSEPH K. CORSON, of Plymouth Meeting, a son, Edward Foulke Corson, 4th, May 3.

TO DR. AND MRS. WILLIAM W. MATTSON, JR., of Sayre, a daughter, Bianca Deitz Mattson, May 5. Mrs. Mattson is the daughter of Dr. and Mrs. George W. Deitz, of Philadelphia.

Engagements

GLADYS Z. LONDON, M.D., of Philadelphia, to Samuel P. Ivins, M.D., of Chester.

MISS PAULINE THAYER TALBOTT, of New York, to Mr. Owen Jones Toland, son of Dr. and Mrs. Owen J. Toland, of Wynnewood.

MISS ELEANOR PYLE, of Toughkenamon, to Mr. Herbert W. McKinstry, son of Dr. and Mrs. Herbert S. McKinstry, of Kennett Square.

MISS BETTY-TERRY WOOD, daughter of Dr. and Mrs. Charles T. Wood, of Prospect Park, to Mr. Raymond W. Dewees, Jr., of Wilkes-Barre.

MISS ELIZABETH THROCKMORTON JOHNSON, daughter of Dr. and Mrs. William T. Johnson, of Swarthmore, to Mr. Richard Bowman Wray, also of Swarthmore.

Marriages

MISS JOAN HELENE FELDMAN, of New York, to Samuel D. Kron, M.D., of Philadelphia, May 7.

MISS IDA VIRGINIA RAYMOND, daughter of Dr. and Mrs. Malcolm L. Raymond, of Johnstown, to Mr. Edward Alexander Gordon, May 19.

MISS DOROTHY MAE KANE, daughter of Dr. and Mrs. Leo A. Kane, of Philadelphia, to Mr. Edward V. Baslawski, of Connecticut, April 29.

MISS JULIA WESTKOTT SCHEFFEY, daughter of Dr. and Mrs. Lewis C. Scheffey, of Merion, to Mr. Harvey Mahlon Buckman, of George School, May 6.

MISS AGNES HUTCHINSON STROUD, daughter of Dr. and Mrs. William D. Stroud, of Villanova, to Mr. Harold Appleton Ball, Jr., of Philadelphia, May 12.

MISS CATHLEEN BRIGGS CONLEY, of Philadelphia, to Norman James Quinn, Jr., M.D., son of Dr. and Mrs. Norman J. Quinn, of Atlantic City, N. J., May 13.

It is extremely important that doctors and all voting-age members of their families be registered to vote in November. Please do not neglect your duty as a citizen.

Deaths

☉ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

☉ Charles E. Ziegler, Pittsburgh; University of Pennsylvania School of Medicine, 1900; aged 79; died April 26, 1950. Renowned as a surgeon, physician, writer, teacher, and inventor, Dr. Ziegler was internationally known in medical circles. He was one of America's foremost teachers in obstetrics and invented the widely used umbilical cord clamp bearing his name. As early as 1909 he did the first organized prenatal work in Pittsburgh. He was responsible for the plans, furnishing and equipment of Elizabeth Steel Magee Hospital in Pittsburgh, and started it on its road to eminence as one of the three top maternity hospitals in the United States. In 1912 he was appointed as its first medical director. Dr. Ziegler took graduate work in Berlin and Dresden. He retired four years ago as chief obstetrician at Magee Hospital and made his home at Miami Shores, Fla., until a few weeks before his death. Since 1936 he had been professor of obstetrics at the University of Pittsburgh School of Medicine. He was a Fellow of the American College of Surgeons and a member of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons. Surviving him are his widow and three daughters.

R. Max Goepp, Philadelphia; University of Pennsylvania School of Medicine, 1900; aged 84; died May 18, 1950. Dr. Goepp was the author of *Medical State Board Questions and Answers*, *Dental State Board Questions and Answers*, and *Nurses' State Board Questions and Answers*. In January, this year, he collaborated with Dr. Harrison F. Flippin to produce the eighth edition of *Medical State Board Questions and Answers*. Dr. Goepp at various times was professor of clinical medicine at the University of Pennsylvania and at Jefferson Medical College, professor of medicine at Woman's Medical College, and assistant visiting physician at Philadelphia General Hospital. He was also medical referee of the Aetna Life Insurance Company for 43 years and was medical consultant for the First National Bank of Philadelphia. Surviving are his widow, two sons, and four daughters.

Edward A. Leonard, Upper Darby; University of Pennsylvania School of Medicine, 1905; aged 66; died May 13, 1950, after a long illness. He was formerly chief of the neuropsychiatric section, Philadelphia office of the Veterans Administration. He had been associated with numerous hospital staffs, and formerly was consultant at Norristown State Hospital and Philadelphia General Hospital. He served with the Veterans Administration and its predecessors for nearly 30 years, and for nine years was stationed in Washington, D. C. He retired in 1948. His widow and a sister survive.

○ **I. Bebout Reed**, Crafton; Jefferson Medical College of Philadelphia, 1886; aged 86; died May 3, 1950, following a six-week illness. Dr. Reed had practiced medicine more than 60 years, and because of his love for horses he continued to make his medical calls with a horse and buggy until 1916, some five years after he bought his first automobile. He was widely known for many years for his trotters and pacers, which he frequently entered in races in the Pittsburgh area. He is survived by a daughter and two grandchildren.

○ **John D. Kistler**, Pittsburgh; Hahnemann Medical College and Hospital of Philadelphia, 1909; aged 64; died April 21, 1950, from a bullet wound in his head. He had been in ill health and apparently had made a suicide attempt. Dr. Kistler studied obstetrics and gynecology in Vienna in 1925. He was a member of the senior staff in gynecology at Shadyside Hospital, also a former president of the Allegheny County Homeopathic Society and of the Homeopathic Medical Society of Pennsylvania.

○ **Lewis N. Reichard**, Brownsville; College of Physicians and Surgeons, Baltimore, Md., 1899; aged 73; died May 15, 1950. Last year he was awarded a plaque by the State Medical Society for having practiced 50 years. He was a past president of the Fayette County Medical Society. He was a staff member of the Brownsville General Hospital, and was secretary of the Brownsville Board of Health. His widow and two daughters survive.

○ **Edward S. Rosenberry**, Stone Church; Jefferson Medical College of Philadelphia, 1895; aged 83; died April 29, 1950, after a short illness. He was the oldest practicing physician in Northampton County. Prior to studying medicine, Dr. Rosenberry had taught school for six years. He was a past president of both the Northampton County Medical Society and Lehigh Valley Medical Society. He is survived by his widow, two sons, and two brothers.

○ **Christian Hager**, Braddock; Ludwig-Maximilians-Universität Medizinische Fakultät, München, Bavaria, Germany, 1884; aged 91; died May 16, 1950. Dr. Hager was born in Switzerland, in the house in possession of his paternal ancestors for nine generations. He came to the United States in 1884, and shortly afterward settled in Braddock where he practiced medicine for 65 years. He is survived by his second wife and a son.

○ **Albert R. Garner**, Norristown; Hahnemann Medical College and Hospital of Philadelphia, 1902; aged 73; died May 7, 1950. Dr. Garner was a former director of the Tuberculosis Society of Montgomery County, and a past president of the Montgomery County Medical Society. He also served effectively as chairman of the Public Assistance Advisory Committee in his county. Surviving are his widow, two sons, and a daughter.

Elliott E. Phillips, Ohiopyle; Jefferson Medical College of Philadelphia, 1906; aged 70; died of a heart condition April 30, 1950. He was the town's only physician and had practiced there for 18 years. He was graduated from the Philadelphia College of Pharmacy

before entering medical school. He was an instructor in anatomy at Jefferson from 1907 to 1911. Surviving are his widow, two sons, and a daughter.

○ **Thomas F. Fleming**, Exeter; Baltimore Medical College, Maryland, 1901; aged 76; died May 6, 1950, after an illness of three months. Dr. Fleming was a member of the active medical staff at Pittston Hospital for many years, and in recent years was a member of the consulting staff. He is survived by his widow, five daughters, and a sister.

○ **William K. Seibert**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1905; aged 71; died May 17, 1950, after a long illness. Dr. Seibert practiced in Plumsteadville until 1920, when he moved to Philadelphia and practiced until his retirement in 1941. He was a former medical examiner for the Sun Life Insurance Company of America.

James F. Kelly, Monessen; Bennett Medical College, Chicago, 1906; aged 70; died of pneumonia April 29, 1950. Dr. Kelly had been in practice 44 years, and for the past five years he was physician to the Monessen public schools. He is survived by his widow, three sons, two daughters, a sister, and a brother.

○ **Samuel Axilbund**, Philadelphia; Temple University School of Medicine, 1912; aged 63; died suddenly May 21, 1950. He was also graduated from the Philadelphia College of Pharmacy in 1907. He was on the surgical staff of St. Mary's Hospital more than 20 years. His widow survives him.

Charles Goss, Philadelphia; University of Pennsylvania School of Medicine, 1900; aged 78; died May 6, 1950. Dr. Goss was head of the dermatology departments of Northeastern and Kensington Hospitals. He is survived by his widow, a son, and a daughter.

Raymond G. Long, Wilkes-Barre; Hahnemann Medical College and Hospital of Philadelphia, 1907; aged 68; died May 5, 1950, following an illness of several weeks. He formerly practiced in Sweet Valley and Nanticoke, retiring 25 years ago. A brother survives.

○ **Cyrus W. Fridy**, Collegeville; University of Pennsylvania School of Medicine, 1904; aged 72; died May 13, 1950, after a short illness. Dr. Fridy was retired. He was formerly on the staff of Presbyterian Hospital. Two sons survive.

○ **Henry D. Hart**, Genesee; Baltimore Medical College, Maryland, 1893; aged 89; died April 18, 1950, from a cerebral hemorrhage while trout fishing in the Genesee River. He is survived by a son.

○ **James C. Borland**, Falls Creek; Jefferson Medical College of Philadelphia, 1905; aged 72; died recently. He was not in practice.

Miscellaneous

THE FOLLOWING OFFICERS HAVE BEEN ELECTED by the Pittsburgh Obstetrical and Gynecological Society for the coming year: president, Eugene A. Conti, M.D.; vice-president, Clarence H. Ingram, Jr., M.D.; secretary, David Katz, M.D.

THE ANNUAL MEETING OF THE UNDERGRADUATE RESEARCH SOCIETY of Hahnemann Medical College was held on May 24 at the Klahr Auditorium, Philadelphia. Original student papers were presented, and Priscilla White, M.D., of Boston, spoke on "Juvenile Diabetes."

THE SHRINERS' HOSPITAL FOR CRIPPLED CHILDREN in Philadelphia will receive the income from the bulk of the \$56,000 estate of William K. Seibert, M.D., Philadelphia, who died May 17, 1950. He was a widower, and the bequest to the hospital was made as a memorial to his son who died in 1911.

W. EDWARD CHAMBERLAIN, M.D., professor of radiology at the Temple University School of Medicine, Philadelphia, has been elected president of the Harvey Cushing Society, a national medical organization devoted to the study and advancement of neurologic surgery. Dr. Chamberlain is a charter member of the group, founded in 1932 and named for its patron, Dr. Harvey Cushing.

FRANCIS R. PACKARD, M.D., throat specialist and medical historian of Philadelphia, who died April 18, 1950, willed to the College of Physicians, of which he was a former president, his collection of books and lantern slides on the history of medicine and allied sciences. Dr. Packard owned one of the largest medical libraries in the United States.

AT THE ANNUAL BUSINESS MEETING OF THE PHILADELPHIA LARYNGOLOGICAL SOCIETY, May 2, the following officers were elected for the coming year: Thomas

F. Furlong, Jr., M.D., president; Harry P. Schenck, M.D., vice-president; William J. Hirschler, M.D., treasurer; and John J. O'Keefe, M.D., secretary. Drs. Valentine M. Miller, Chevalier L. Jackson, and George L. Whelan were elected to the executive committee.

J. ROBERT WILLSON, M.D., professor of obstetrics and gynecology at Temple University School of Medicine, Philadelphia, has been named a member of the Unitarian Service Committee's 1950 Medical Mission in Germany, in which a team of ten topflight doctors and scientists will conduct medical refresher courses in Germany for physicians whose opportunities to learn were at a standstill during the war.

CAPT. MELVILLE ASHTON, veteran naval medical officer and one-time head of the Bethesda Naval Hospital, will become chief of the new division of Consolidated Health Centers in Philadelphia. The naval officer's function will be to direct the health center program of the city, which is gradually being expanded. He is a former commandant of the Philadelphia Naval Hospital and served in many of the Government's largest institutions.

MORE THAN 200 ASSOCIATES AND FRIENDS OF E. ROGER SAMUEL, M.D., president of The Medical Society of the State of Pennsylvania and a practitioner in Mt. Carmel for 35 years, acclaimed Dr. Samuel at a testimonial dinner on April 21. This celebration was arranged by the members of the Mt. Carmel Medical Society, and among the guests were doctors of medicine and of dental surgery and pharmacists accompanied by their ladies from several surrounding counties.

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THE AMERICAN SOCIETY FOR THE STUDY OF STERILITY offers an annual award of \$1,000, known as the Ortho Award, for an outstanding contribution to the subject of infertility and sterility. Competition is open to those in clinical practice as well as individuals whose work is restricted to research in the basic sciences. Essays submitted for the 1951 contest must be received not later than March 1, 1951. The prize essay will appear on the program of the 1951 meeting of the society. For full particulars, address the American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

THE NATIONAL MENTAL HEALTH FOUNDATION, INC., the National Committee for Mental Hygiene, Inc., and the Psychiatric Foundation will shortly pool their resources and work in a single unit to be known as the National Association for Mental Health, the dual object being to dispel confusion as to their purposes and improve research and treatment in the field of mental illness. The new association will carry on large-scale educational activities, also seek the cooperation of organized psychiatry and state and local citizens' groups working for mental health, as well as help to establish additional voluntary mental health agencies in other communities.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE will hold its twenty-eighth annual scientific and clinical session Aug. 28, 29, 30, 31 and Sept. 1, 1950 inclusive, at the Hotel Statler, Boston, Mass. Scientific and clinical sessions will be given on the days of Aug. 28, 29, 30, 31 and Sept. 1, 1950. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28, 29, 30, and 31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects, and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 N. Michigan Ave., Chicago 2, Ill.

ical sessions will be given on the days of Aug. 28, 29, 30, 31 and Sept. 1, 1950. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28, 29, 30, and 31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects, and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 N. Michigan Ave., Chicago 2, Ill.

NEW BLUE SHIELD REPORT FORMS MAILED TO PARTICIPATING DOCTORS

New Blue Shield Doctor's Service Report forms have been mailed to the more than 8500 participating doctors by Medical Service Association of Pennsylvania, with instructions for their use.

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Lowsley, O. S. & Kirwin, T. J.: Clinical Urology—Vol. 1, 2 Ed., Balt., Williams & Wilkins, 1944—P. 31.

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Stanley, Phyllis: The American Journal of Medical Technology—Vol. 6, No. 6, Nov., 1940 and Vol. 9, No. 1, Jan., 1943.

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For Sale.—Late model Jones metabolism machine. Used one time. Reasonable. Write J. EDWARD BOOK, M.D., Newport, Pa.

Wanted.—Physician with Pennsylvania license to do general practice in western Pennsylvania town for month of August while doctor is away. Write Dept. 208, PENNSYLVANIA MEDICAL JOURNAL.

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Residency Available.—A residency in radiology is available at the Mount Sinai Hospital of Philadelphia beginning July 1, 1950. Approved for three-year resident training. Over 300 beds and approved in all specialties. Write ADMINISTRATOR, MOUNT SINAI HOSPITAL, Fifth and Reed Streets, Philadelphia 47, Pa.

Wanted.—Resident physician, July 1, or later in 1950, single or married, for general medical and surgical hospital. Approved by A.C.S. Near Wilkes-Barre. Excellent salary and duty schedule. Attractive living quarters. Further particulars furnished. Write SUPERINTENDENT, Nanticoke State Hospital, Nanticoke, Pa.

For Sale.—Combination home and office in community of 10,000 people. General practice established 35 years. Located in northeastern Pennsylvania. Chief industries are railroads, manufacturing, and farming. Open-staffed hospital. Retiring. Write DEPT. 187, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Recent graduate to take over general practice for one year beginning September, 1950, or February, 1951, in town 15 miles from Allentown, in cement and garment manufacturing section. Town and three-mile area has population of 25,000. Net yearly income \$20,000. Office and home equipped and furnished. Write Dept. 203, PENNSYLVANIA MEDICAL JOURNAL.

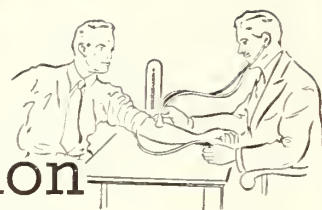
For Sale.—General semi-rural practice established 15 years. Modern house and semi-detached office complete with insulation, new oil hot water heating system, x-ray, ultraviolet, drugs, etc. Six miles from new general hospital employing full-time roentgenologist and pathologist. Will introduce. Specializing. Write DEPT. 188, PENNSYLVANIA MEDICAL JOURNAL.

Opportunities for Physicians.—Are you interested in a position in one of our county or district health departments? Salary \$5,600 to \$7,200 with \$70 a month travel allowance. Public health scholarships available with liberal stipends. Men and women physicians eligible. Write FELIX J. UNDERWOOD, M.D., Mississippi State Board of Health, Jackson, Miss.

Wanted.—General practitioner for assistant to well-established and older Fellow of the American College of Surgeons. Married man desired. Good hospital facilities. Salary for first six months, then percentage. Apartment available in suburban area of twin cities. Great future. Minnesota license or national boards necessary. Write Dept. 207, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Staff physician for 105-bed private tuberculosis sanatorium, central Pennsylvania. Medical and surgical phases covered, including bronchoscopy; outpatient service. Excellent opportunity to learn. Pennsylvania license or reciprocity required. House and maintenance for physician and family; congenial surroundings. Inquire MEDICAL DIRECTOR or SUPERINTENDENT, Devitt's Camp, Allenwood, Pa.

Wanted.—A Philadelphia allergist, diplomate in internal medicine, Fellow of American Academy of Allergy, will give short courses in the management and treatment of allergic diseases; preparation of dilutions for testing; interpretation and evaluation of histories and results of testing; pollen and dust extract preparation; also new methods of desensitization for inhalants, pollen and dust. Write DEPT. 186, PENNSYLVANIA MEDICAL JOURNAL.



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BOOK REVIEWS

Mayo Clinic Diet Manual. By the Committee on Dietetics of the Mayo Clinic. Philadelphia: W. B. Saunders Company, 1949. Price, \$4.00.

This manual represents the critical and authoritative condensation of a group's many years' experience with therapeutic and diagnostic medical and surgical dietary demands.

The information is brief, detailed, and easily accessible. The nutritional adequacy of each diet is noted where necessary, also provision for supplemental medication where so advised. The appendix is generously supplied with tables recording foods high in acid ash, foods high in alkaline ash, recommended dietary allowances, foods high in calcium, cholesterol, iron, and sodium, heights and weights, etc.

This manual provides the busy practitioner, as well as the especially interested dietitian, with complete and successfully tried dietary programs.

Diseases of the Heart. By Charles K. Friedberg, M.D., Associate Physician, Mt. Sinai Hospital, New York; Lecturer in Medicine, Columbia University. 1081 pages with 79 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$11.50.

This first edition marks the entry of a new book into the well-covered field of cardiology. It is complete in one volume, perhaps the most complete book of its kind. It is well written, comprehensive in text and index, and is easy to read. The material is presented in six parts with many subdivisions to each part. The pathologic physiology of cardiac disorders and the pathogenesis of symptoms and signs of diseases of the heart and circulation are presented in an easily understood manner. The relationship of these basic phenomena to the clinical aspects of the various heart diseases is well integrated.

Space in the book is allotted to diseases in proportion to their frequency and importance in practice; for example, ten chapters are devoted to failure of the circulation, eight to coronary disease, three to rheumatic fever, three to rheumatic heart disease, and so on. Up-to-date information on congenital heart disease and its diagnostic phases is included. Insurance and medicolegal aspects of heart disease and surgery in the cardiac are well presented. A voluminous bibliography is included, which is so complete as to leave no room for criticism. The author does not permit himself to be projected into controversy. He presents all views on a subject and then includes his own. Final evaluation is the pleasure of the reader.

There are few faults to find with this book. Perhaps the most glaring is the absence of a section on physical examination and the findings in normal hearts. For the beginner in cardiology this omission makes the book difficult to understand unless reference to other texts is made. For the well-oriented physician this is no omission.

Perhaps this review is overenthusiastic, but this is a natural reaction to a good book which should become better with succeeding editions. Dr. Friedberg's book is a valuable addition to the subject of cardiology.

Postgraduate Gastroenterology. As presented in a course given under the sponsorship of the American College of Physicians in Philadelphia, December, 1948. Edited by Henry L. Bockus, M.D., Professor of Gastroenterology, University of Pennsylvania Graduate School of Medicine. 670 pages with 258 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price, \$10.00.

Any attempt to place in one volume a composite coverage of recent authoritative trends in gastroenterology offers a complex problem. Here under a single cover is a collection of lectures by a group of prominent authors, investigators, and lecturers representing primarily the Philadelphia group, particularly the University of Pennsylvania, presented in a course in gastroenterology during the week of Dec. 6-11, 1948, under the auspices of the American College of Physicians.

Topics discussed are esophageal disorders, gastric secretion and analysis, gastric neoplasms, recent contributions to the knowledge of peptic ulcer, the application of neuropsychiatry to gastro-intestinal problems, the pancreas, abdominal pain, the liver, intestinal obstruction, non-specific enteritis, jaundice, and colonic diseases. Despite a full program, such topics as sprue and cirrhosis of the liver were conspicuous by their absence.

Much of the material will be familiar to a reader of the standard journals of medicine and gastroenterology, as much of it has been or will be published elsewhere.

Controversial subjects are easily found in gastroenterology. An example is the constant re-evaluation of the various clinical and laboratory procedures employed in the distinction between surgical jaundice and medical jaundice. Several procedures considered of value in some quarters but which did not appear in the discussion are roentgen-confirmed duodenal intubation for bilirubin measurement as well as the determination of feces urobilinogen over a period of one to three days

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where laboratory facilities permit such procedures. The van den Bergh test has not lost complete favor as the author would have us believe, particularly, say, in Minneapolis. To be commended was the reiteration that a well-taken and critically reviewed history is of great importance. Again, as the author emphasizes, evaluation of the liver is a difficult procedure, as its functions are many and no single test provides adequate appraisal.

The diagnosis of acute pancreatitis is being made more frequently without surgical exploration. A terse, well-constructed review of this problem is presented. Proper emphasis is given to the non-specificity of some of our present laboratory procedures, for example, the determination of the blood amylase and lipase. Perhaps more emphasis could have been placed upon the pattern of the pain, particularly in the differentiation between cholelithiasis, acute hemorrhagic pancreatitis, and myocardial infarction. The management of pain during the exacerbations of recurrent progressive pancreatic insufficiency remains an urgent problem. Despite the authors' comments regarding the use of chemical and surgical sympathetic blocks, it is increasingly apparent that these procedures are not the answer to the problem. Not mentioned but worth further trial is the use of pancreatic substitution products in the presence of manifestations of pancreatic insufficiency.

The so-called post-cholecystectomy syndrome was discussed much more clearly and specifically than in the average treatise on this problem.

Fluid balance was expertly discussed and many who read this excerpt from the authors' anticipated book-length review will be pleased with the clarity and ease of manner in presentation.

The surgical management and case selection for ileostomy are discussed. Not mentioned is the increasingly popular and apparently successful use of a skin graft covering of 3 to 5 cm. of exposed intestine, greatly diminishing skin and feces collection problems.

The illustrations in the roentgenographic representation have been generously provided. Their selection and reproduction are excellent.

This book, admittedly incomplete, and reproducing information available in the recent literature, does provide under a single cover a rather comprehensive evaluation of present trends in gastroenterology. Authoritatively produced, yet written with an air of informality which makes for easy reading, this book should be quite popular.

Urological Surgery. By Austin Ingram Dodson, M.D., F.A.C.S., Richmond, Va., Professor of Urology and Urologist to the Hospital Division, Medical College of Virginia; also Urologist to Crippled Children's Hospital, St. Elizabeth's Hospital, and St. Luke's Hospital and McGuire Clinic. Second edition with 645 illustrations. St. Louis: The C. V. Mosby Company, 1950. Price, \$13.50.

This new edition of Dr. Dodson's book follows the precepts outlined in the earlier edition and becomes a book of reference for the student, the general practitioner, the surgeon, and the urologist.

The new chapter on preoperative and postoperative care is of value to any physician who might peruse it. This care, as Dr. Dodson relates, is exceedingly impor-

tant in urologic cases which are notoriously poor risks as to age and general physical condition; however, the general surgeon benefits from the helpful suggestions and the new techniques.

The wording of the new edition is concise and understandable and the illustrations throughout are an integral part of the text, aiding greatly in the completeness of the presentation. The new concepts of acid-base balance, fluid administration, and blood transfusions are well presented to any physician engaged in surgery. The chapters on recognized surgical procedures are streamlined in the light of present-day knowledge of antibiotics and the surgical aids previously mentioned.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

The Law of Medicine. By Parnell Callahan, A.B., LL.B., Member of the New York Bar, and Justin Callahan, A.B., M.D., Assistant Attending Obstetrician and Gynecologist, New York Hospital; Instructor in Obstetrics and Gynecology, Cornell University Medical School; Assistant Attending Obstetrician and Gynecologist, St. Clare's Hospital; Junior Assistant Attending Gynecologist, Roosevelt Hospital. Legal Almanac Series No. 20. New York: Oceana Publications, 1950. Price, \$1.00 paper-bound, \$2.00 cloth-bound.

You and Your Heart. A Clinic for Laymen on the Heart and Circulation. By H. M. Marvin, M.D., T. Duckett Jones, M.D., Irvine H. Page, M.D., Irving S. Wright, M.D., and David D. Rutstein, M.D. Foreword by Paul D. White, M.D. New York: Random House, 1950. Price, \$3.00.

Diseases of the Eye, Ear, Nose, and Throat. A Text-book for Nurses. By Albert P. Seltzer, M.D., Sc.D. (Med.), F.I.C.S., F.A.C.S., Assistant Professor of Otolaryngology, Graduate School of Medicine, University of Pennsylvania; Associate Chief in Ear, Nose, and Throat, St. Luke's Medical Center; Consulting Otolaryngologist to the Mercy-Douglas Hospital, Philadelphia; Instructor of Nurses at St. Luke's Medical Center. With the technical assistance of Bernard C. Gettes, M.D., Diplomate, American Board of Ophthalmology; Instructor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania; Instructor of Nurses in Ophthalmology, Wills Hospital; Chief Ophthalmologist, Stetson Hospital. First edition. New York: McGraw-Hill Book Company, Inc., 1950. Price, \$4.00.

Proctology in General Practice. By J. Peerman Neselrod, B.S., M.S., M.Sc. (Med.), M.D., F.A.C.S., F.A.P.S., Associate in Surgery, Northwestern University Medical School; Associate Surgeon, Division of Proctology, Evanston Hospital, Evanston, Ill.; certified by the Central Certifying Committee in Proctology (Founders' Group) of the American Board of Surgery; Commander (MC), USNR. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$6.00.

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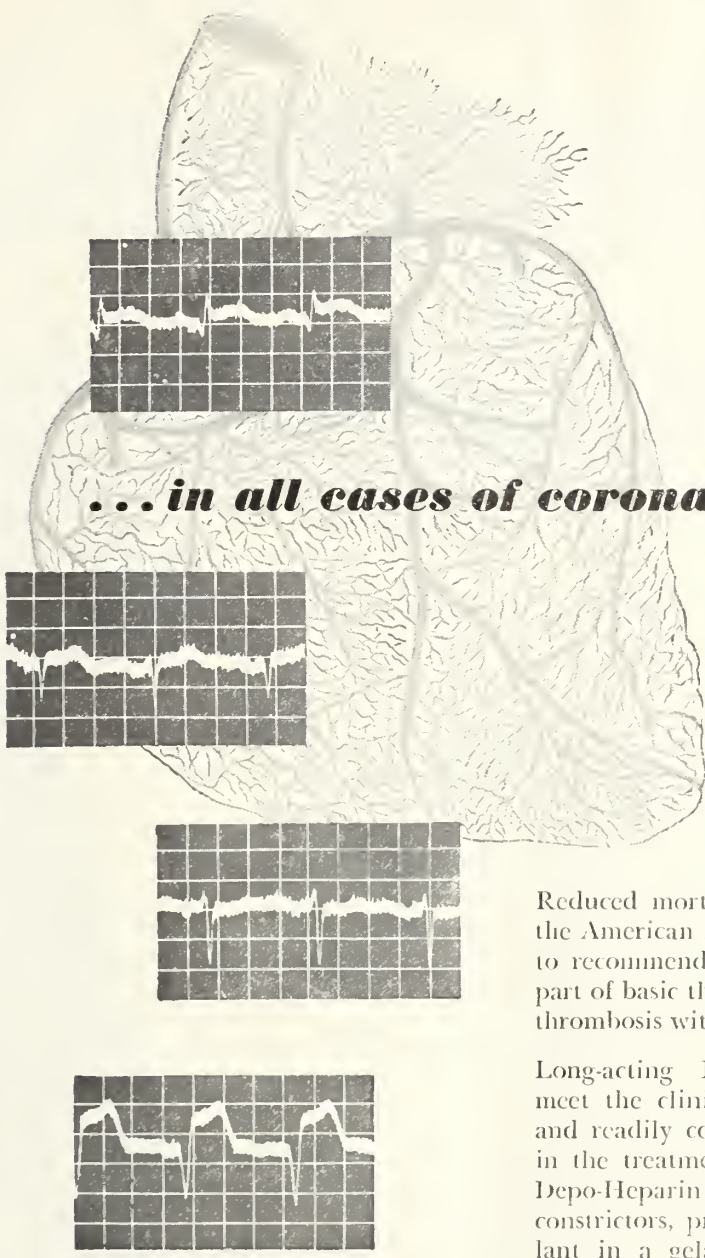
Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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1. Wright, et al: *Am. Heart J.* 36,801 (Dec.) 1948.

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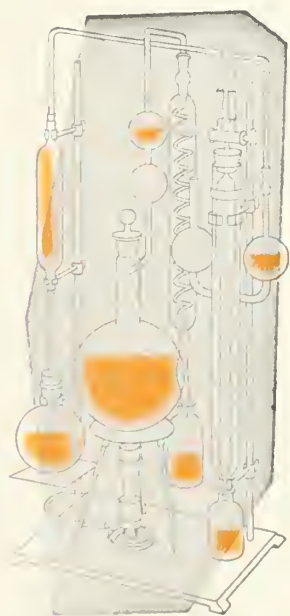
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LETTERS

Fifty Years

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Thank you and The Medical Society of the State of Pennsylvania for the gracious thought of marking the fiftieth year of those of us who have been in medical practice that length of time. It has been a happy rewarding experience in spite of the ups and downs that come to all doctors.

WILLIAM D. SCHRACK, SR., M.D.,
Phoenixville, Pa.

GENTLEMEN:

Thank you for the invitation to be an honor guest at the luncheon meeting of the Second Councilor District on May 10. I had decided not to go and sent my reply to that effect last week, but have changed my mind and will be on hand to receive the 50-year testimonial.

GEORGE T. LUKENS, M.D.,
Conshohocken, Pa.

GENTLEMEN:

I would like to thank the State Medical Society through you for the testimonial for fifty years' practice which I received with some mixed emotions at the 1950 meeting of the Tenth Councilor District, but I am informed that my family will treasure it for years to come.

WILTON H. ROBINSON, M.D.,
Pittsburgh, Pa.

ON YOUR OFF

GENTLEMEN:

"When you are on your off, stay off." When a Pennsylvania Dutchman says he is on his "off," he means that he is taking his vacation and, Dutch-like, he is not doing it half-heartedly—he is *really* "off."

Doctors are a notoriously overworked group, and yet many of them take "busman's holidays." I live in a community where the only lucrative crop is the tourist. Consequently, the doctors as well as all the other permanent residents must make their hay when the summer sun shines. Unfortunately, however, a number of physicians from the surrounding metropolitan centers vacation in the area. I say "unfortunately" because "vacation" is not quite the correct descriptive term; many of them continue to practice—here. Obviously this is not unethical, but I feel that it is unkind to the local physician.

Naturally there are emergencies which any doctor should answer and there may be friends or old patients as well who desire advice, but to follow one's patients as does the professor of medicine of a medical school to their mutual summer resort and continue to treat

them—and worse still, many others that his reputation attracts, seems to me to be not quite fair to the less well known local doctors.

I am quite sure that "vacationing" doctors who follow this practice do not realize how seriously this affects the local men. During the winter a great percentage of the local populace is hard pressed to pay for medical care which they must have—and which we give. We must therefore count heavily on the summer "vacation" period to help carry us along. And certainly it would seem that if a doctor can afford a vacation, he should be able to afford not to cut in on another's practice during that time. In other words—when he is on his "off," he should stay off!!

_____, M.D.
Pennsylvania.

IS THE BRITISH HEALTH SERVICE BREAKING DOWN?

A paid advertisement in the English magazine *Punch* might provide the answer to this question.

In a recent issue the British United Provident Association ran an ad, saying: "Which Would You Choose in the Event of Illness?—Private Treatment or General Ward!" Then the text said: "The National Health Service ensures that everyone receives medical and, if necessary, hospital treatment in the event of illness or operation. To many people, however, the necessary formalities, the waiting and, finally, treatment in a general ward, are disconcerting both in anticipation and in practice."

Those are harsh words against a health system which many proponents of socialized medicine in this country would have everybody believe is working beautifully.

Furthermore, the ad says that "the British United Provident Association offers an inexpensive alternative. For a moderate annual subscription, graded to suit individual means and requirements, members can make their own arrangements for speedy and private treatment in nursing home or hospital paybed and the whole or major portion of the expenditure is refunded by B.U.P.A."

In other words, the British insurance firms apparently are out to compete with the government health service in providing better and speedier medical care. Subscribers who have to pay for the health plan in taxes would also have to pay for the insurance premium if they prefer a service better than the government can offer.

As Dr. Walter W. Mott of White Plains, N. Y., says: "I think this indicates a significant trend."—AMA Secretary's Letter, June 5, 1950.



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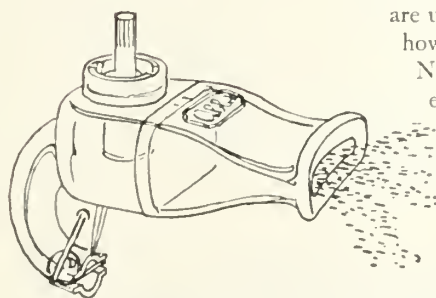
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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Reduction of Maternal Mortality Due to Hemorrhage

CHARLES A. GORDON, M.D.

Brooklyn, N. Y.

THE SLOW dragging realization that hemorrhage is the most frequent and the most important cause of maternal death is the principal reason for its failure to parallel the rate of reduction in the number of deaths due to infection. Hemorrhage should yield to preventive and positive measures more readily than any one of the other three great causes of puerperal death—infection, toxemia, and heart disease, yet it has not. Perhaps not everyone will concur in this opinion, but, for myself, after years of looking backward at the case reports of maternal death in Brooklyn, I am certain of it.

In the face of a tremendous increase in the number of births in the United States, the total number of maternal deaths has been cut in half during the last ten years, saving about 5000 mothers' lives. All the major causes of maternal death have declined, yet with widening racial differential and not equally. Infection, yielding to the pressure of specific therapy, shows the greatest gains. Toxemia marks time. It is difficult to discover the true position of cardiac disease, for much of the mortality associated with it during pregnancy has not been assigned to puerperal causes. Hemorrhage not only lags behind but shows a relative increase.

Everywhere throughout the United States, where it may be possible to draw conclusions

from case reports of death, not certificates or statistics, over any considerable period of time, hemorrhage will be found, I believe, to be the principal cause of maternal death.

For the most part obstetricians agree upon the fundamental concept of what constitutes good obstetric practice. Our ante-partum care is thoughtful, forward-looking, and conscientious. If, along its course, hospitalization should become necessary, we insist upon it. We do not allow the patient or her relatives to follow their own inclinations. We may even threaten to retire from the case if our patient should decline hospitalization in the event of danger signals like ante-partum hemorrhage, preeclampsia, or cardiac decompensation.

We do not perform cesarean section for eclampsia, nor for preeclampsia unless in the interest of the baby or when other therapy has been clearly unsuccessful. The broad pattern of treatment of toxemia is widely accepted. Therapy is not specific, however, and any considerable statistical gain will depend upon further research.

The obstetrician will have none of high forceps, and avoids mid forceps when he can. He shrinks from manual dilatation and Dührssen incisions; yet with consistent increase in the number of hospital deliveries, interference grows more common. In 1948, for example, in the entire city of New York, but one-third of the births

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 27, 1949.

were conducted without any operative procedure to hasten delivery, and in the last ten years the incidence of cesarean section has doubled.

Nearly every woman who loses her life from infection has had her chance with sulfonamides or penicillin. Antibiotics are easy to obtain and administer, and fever in the puerperium, so easily discovered, is a clear-cut indication for their use. And intra partum for prophylaxis, though the usefulness of specific therapy is not so clearly established, antibiotics are in common use. The treatment of puerperal infection, no longer expectant, is, for the present at least, fairly uniform.

Most women who die of hemorrhage and shock have not had such standardized care. No matter how severe it has been, many look with equanimity at the hemorrhage associated with the third stage of labor once it has stopped. Yet even moderate loss of blood, and particularly in those women who go into labor with unfavorable hemoglobin values, may cause death or predispose the patient to infection to which she may succumb later. Before the advent of blood transfusion therapy it was easy to number the febrile patients in a large obstetric ward by their pallor alone. Hemorrhage will continue to be the principal cause of maternal death until ample reserves of blood are on hand in every hospital, with facilities for its timely use.

It should be the primary purpose of every maternal welfare program to insist that our most serious problem is hemorrhage and shock. Not all, but perhaps nearly all of these deaths are preventable, or at least contain clearly controllable factors. Even abortion contributes a fair increment to the hemorrhage total. Though it has often been said that mortality from abortion is but rarely due to actual loss of blood alone, death was due directly to hemorrhage and shock in 16 or 11 per cent of the 146 deaths assigned to abortion in Brooklyn from 1936 to 1948.

It would be difficult to piece together all the great mass of detail available for discussion of the management of lacerations of the birth canal, atony, rupture and inversion of the uterus, or to discuss the implications of inertia, analgesia and anesthesia, particularly ether, or the risk of version or delivery by forceps through an incompletely dilated cervix. Death at the time of delivery is more often due to hemorrhage than to any other cause. And hemorrhage associated with the third stage of labor is its most important single factor.

Present-day management of the placental stage, devised to reduce blood loss at that time, outdates our textbooks. Long-accepted concepts of the mechanism of separation and extrusion, the retroplacental clot, the teachings of Duncan and Schultze, and even the apparently sound and conservative advice to wait for signs of separation are no longer valid. For generations the name of Crede has been taken in vain by great numbers of students and practitioners of obstetrics who had not heard of the gentle nature of the expression he practiced. The sins committed in his name are legion.

Dieckmann's¹ studies show that if we will but wait a little while, say half to one minute after the delivery of each shoulder, the placenta will separate with the birth of the baby and may be expressed within a very few minutes, or just as soon as the uterus is seen to have assumed a globular shape (Calkins' sign). Expression is best effected when the uterus is kept from descent into the pelvis by a restraining suprapubic hand and is not squeezed. Slight traction on the cord will help, but only when the placenta lies in the birth canal.

Dieckmann points out that separation of the placenta begins just before birth of the baby and is completed within five or six minutes after delivery. Birth under anesthesia, perhaps with episiotomy or low forceps, is not the natural method—the fetus is delivered too rapidly. The pattern of natural labor should be imitated, with studied delay in delivery of the fetus after the head has been born. Dieckmann's study is of the greatest practical importance and its worth can be easily proved by anyone who will follow his advice. Up to now I have proved it a hundred times myself. Even the obstetrician who is in a hurry will save himself time and anxiety by following this technique, and the patient will save blood.

Only in the absence of hemorrhage may the placenta be awaited for as long as one hour. If slow delivery is practiced, both hemorrhage and delay will be scant. Under any circumstances the placenta should be removed manually without hesitation if gushing occurs, or for the repeated small bleedings which are so dangerous. Provided aseptic technique is observed, the danger of manual removal is minimal. The risk of infection associated with it increases directly with procrastination and repeated bleeding. If uterine hemorrhage continues or recurs after extrusion or removal of the placenta, the uterus should be

explored even though the placenta was thought to be intact. And the uterus should be quickly but carefully explored after every version and, as a matter of fact, after any obstetric operation if shock appears to be out of proportion to the amount of blood lost.

Shock will follow hemorrhage soon enough, and death may occur suddenly. Its symptoms depend upon the extent and rate of reduction of blood volume and the duration of the syndrome. Anesthesia, acidosis, psychic trauma, and tissue injury all hasten its appearance. Prevention of factors other than hemorrhage is of obvious importance.

Certainly the most important factor in the treatment of shock is its early recognition. The pulse rate is quickened as blood volume decreases. To the good observer, diminution in the size of the pulse is perhaps the earliest clinical sign available. Finally, the radial pulse will be lost. Blood pressure is easily the most practical method of assessing the extent of circulatory failure; and since there is no better way of knowing the response to treatment, the blood pressure cuff should remain on the arm so that readings may be taken frequently. Not that low blood pressure, systolic or diastolic, is an early symptom, for both will remain normal until considerable blood has been lost and diminishing venous return diminishes cardiac output. It is not possible to say just what the critical level is, for pressure may have been high before delivery, or consistently low for months ante partum.

Cold clammy skin, ashen cyanotic pallor, shallow gasping respiration, apathy, and loss of consciousness are ominous signs. Recurrent shock in one who is thought to be responding to treatment is a serious sign indeed. It is difficult to know when shock has become irreversible. Only when bleeding has completely stopped and sufficient blood has been given by transfusion without blood pressure response may this term be used. Deepening cyanosis and unconsciousness do not prove irreversibility if these criteria have not been fulfilled.

In an emergency due to hemorrhage the obstetrician depends but little upon laboratory examinations other than typing, cross-matching, and Rh determination. The blood count will not indicate the extent of blood loss, as hemodilution may not be present, or prior anemia or dehydration make it unreliable. Hematocrit is better than hemoglobin estimation.

Treatment of Hemorrhagic Shock

Treatment of hemorrhagic shock cannot be reduced to the art of a laboratory science. In much of the contemporary research on shock there appears to be a lack of understanding and appreciation of the commonly shared experiences of obstetricians. The experimental method is so often divorced from life, locked in a laboratory full of small animals. There is nothing fundamentally new. We should not be confused or turned aside from our conviction that transfusion of large amounts of blood is the first obligation of treatment.

General supportive measures are helpful. Morphine should be given for pain, restlessness, and relief of psychic trauma. If shock is deep, however, morphine may not be absorbed, so $\frac{1}{8}$ to $\frac{1}{6}$ gr. should be given intravenously.

Cold blood-soaked linen should be replaced by a warm dry blanket, yet enough heat to induce sweating will decrease circulatory volume and defeat our purpose. Lowering the head of the delivery table will help syncope and make the patient feel better.

Since anoxia or hypoxia is always present in hemorrhagic shock, oxygen would appear to be rational therapy; yet since the cause of anoxia is defective transport of oxygen due to loss of carriers, its value may be questioned. Best given by hood rather than a mask, which is apt to increase apprehension and restlessness, it should be given in high concentration and preferably during the actual administration of blood.

In hemorrhage and shock, cardiac failure occurs only near death when steadily diminishing venous return has reduced cardiac output to an inadequate level. Cardiac stimulants are contraindicated. Pressor substances should not be used since they will reduce cardiac output still further by slowing venous return.

Crystalloid solutions are effective only when blood loss has not been serious. They are useful in preventing shock, but without value and probably dangerous once it has been established. Unless plasma colloids are sufficient to maintain circulatory volume, aqueous solutions will not remain in the blood stream, and their continued administration will reduce blood volume still further.

Pooled plasma, unless ultraviolet irradiation has been used in processing, is dangerous and should not be administered except in dire emergency. Gelatin² is safe and will fully meet the temporary indication as well as plasma without

the risk of transfusing an icterogenic agent which will cause homologous serum hepatitis. Gelatin will interfere with subsequent cross-matching for transfusion of blood, but this disadvantage may be overcome if enough blood for several cross-matchings has been obtained before its administration.

From 1500 to 2000 cc. of blood should be cross-matched; the use of 500 cc. approaches futility. Rh-negative Group O low titer blood may be used with perfect safety without cross-matching. It is well to use as large a needle as possible for withdrawal of blood for cross-matching, so that it may be used for immediate infusion of suitable gelatin or plasma or blood as soon as it is available. The largest needle that can be inserted into the vein should be used. A B-D No. 17 needle will be found generally useful, while No. 19 may be good enough. Needles of smaller bore will unduly slow transfusion.

The patient who needs blood at all should get it quickly. Theoretical considerations like overburdening the right side of the heart or causing pulmonary edema by overload are not borne out in practice, if circulatory volume has been depleted. Large amounts of blood may be speedily transfused, watching the blood pressure and the general appearance of the patient however in women with cardiac disease or severe toxemia.

Methods of transfusion in common use are hard on patient, staff, and nurses, time-consuming, and often associated with extravasation of blood into the tissues, pain, great ecchymoses, and perhaps loss of a vein with failure to make use of all the blood available. The manufacturer of standard equipment, or the obstetrician himself, may reinforce tubing connections so that they will not blow out under pressures up to 200 mm. of mercury. Using a sphygmomanometer bulb or a 50 cc. syringe, 500 cc. of blood may be safely transfused in less than ten minutes. The gravity method is practicable only when a large bore needle is used.

Comment

Hemorrhage is the principal cause of maternal mortality, and for this reason the most important. Maternal death at the time of delivery is

most often due to ante-partum and post-partum hemorrhage.

Today delivery is rarely normal, if that means without some form of analgesia or anesthetic which may change the rhythm and strength of uterine contractions and inhibit voluntary use of the muscles of the abdominal wall. Low forceps and episiotomy will alter placental separation unless the normal pattern and time requirement of normal labor are reconstructed. Slow delivery of the fetus is necessary, and so proper management of the third stage of labor should begin with close attention to that part of the second stage just prior. Whether one will administer an oxytocic with the birth of the posterior shoulder or after extrusion of the placenta will depend upon the experience of the obstetrician. It may be safer to wait until the third stage has been completed.

Even in cesarean section, management of the placental stage should be thoughtful. Retention of cotyledons or membrane is not uncommon. The patient who is returned to her bed bleeding or who has a hemorrhage in the puerperium constitutes a serious problem for management. It is even more important to examine the placenta carefully during the course of cesarean section than after vaginal delivery.

In placenta previa it is important to remember that ante-partum hemorrhage does not cause death, which is due to intra-partum and post-partum hemorrhage, operative trauma, and consequent sepsis. Death is due to mismanagement of delivery.

Maternal mortality can be effectively and considerably reduced by careful consideration of the problems associated with the third stage of labor. The unexpected may happen, but we should be prepared for it.

If only for its own good, every hospital should maintain an adequate blood reserve and make provision for its continuance. And as a matter of conscience no physician should be willing to conduct a delivery other than where he, as well as his patient, can be sure of protection.

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The Medical Profession's Role in Public Welfare

HAROLD B. GARDNER, M.D.

Pittsburgh, Pa.



IT IS NOT necessary to be an intensive student of the art and practice of politics to realize that in free economies a device of distraction has been practiced by those responsible for the conduct of the government whenever they found themselves in difficulties. If their foreign policy

failed, if business declined, if the citizens became restive, uneasy, dissatisfied, and too inquiring, it became necessary to distract their minds—to divert their thinking into other channels. To accomplish this, it was necessary to get the individual to think more about himself and less about his country—to start worrying about his own welfare and less about the inadequacy and inefficiency of the government. Up to that time he had never realized that he was very badly off, but it was easy for the social planners of government agencies and the do-gooders of floundering foundations to convince him that he needed something that he didn't have, that is, public welfare. At once he forgot about foreign policy and the indecision and lack of government policy and became engrossed in his own welfare. Thus the term "public welfare" was born, popularized, and propagandized chiefly as a political device.

You and I realize that public welfare has come to imply many things that have little to do with human welfare or the state of well-being of the individual—that it has become a cloak to cover the schemes and devices of social planners, unstable economists, unsound financiers, and vote-hungry politicians. And the medical profession knows that this all-enveloping cloak shields the political propaganda for socialized medicine and compulsory health insurance. And too, we ourselves know, and we believe the public is begin-

ning to know, that our efforts in exposing the willful distortion of facts regarding medical care in this country, and the political propaganda in back of it, have caused enough rents in this cloak so that it is beginning to leak and sag, and we swear by the oath of Hippocrates that we shall continue ripping this cloak shred by shred until there is not enough of it left to mask and shield the falseness which it now protects. This we have done and shall continue to do by means of our Education Campaign—not by acting as a political unit. This program is a positive contribution to the public welfare, and we shall continue it without fear or favor. We are willing to give the time, we are willing to work, and we are mindful of the dictionary definition of the word welfare—I quote: "more fully, welfare work." Gentlemen, that means *work*.

My position this afternoon is much like that of the pastor who on Sunday morning exhorts the faithful who sit before him, when his message should reach the sinners out on the golf course. I know that each of you here this afternoon are on this job until it is finished, and it is you and I who must continue to carry the burden of the work concerning welfare. The plan—the pattern—the knowledge of how to continue our efforts of acquainting the public with the facts is available, and we ourselves are providing the funds with which to do it. So don't let any one get away with the idea that we don't have the right to assess ourselves to carry on our own educational work. We are not fighting any government but Joe Stalin's, and to date 9100 out of 10,150 of The Medical Society of the State of Pennsylvania's active members have paid their county, state, and AMA dues and I am confident that the rest will fulfill their obligation before Jan. 31, 1950. All we have to do is to continue working.

Important and vital as it may be, the Education Program directed by the medical profession against socialized medicine and compulsory

Read at the Seventh Councilor District meeting held in Williamsport, Pa., May 3, 1950.

Dr. Gardner is president-elect of The Medical Society of the State of Pennsylvania.

health insurance is not the only role the profession plays in public welfare. In the daily routine work of officers, committees and commissions, our society is continually engaged in activities which are a direct contribution to public welfare. May I direct your thoughts for a few minutes to just a few of these activities which at the present moment are of vital importance to "the medical profession's role in public welfare." Our scientific programs must be better than ever—both in the county and state societies—and they must be publicized. The program of the Commission on Graduate Education must be continued and supported. The officers and members of this society cannot in words adequately express to Dr. Smith their gratitude for his untiring efforts in the development and continuance of this program. And, too, we are just as grateful to our members who have participated in these courses, with benefit to themselves and resultant benefit to this society. The public must know that we are continually striving to make better doctors of ourselves so that we may give the people the benefit of progressive medicine. The best way to convince the people of this country that they have the best medical care in the world is to continue to give them the best medical care in the world.

To increase our knowledge of new drugs and surgical techniques, we must assure our medical schools and research departments the continuation of the advantages of animal experimentation which they now possess, and we must support the activity of our Public Health Legislation Committee in the Legislature, also the program of the National Society for Medical Research. In this activity we shall lean heavily upon the Woman's Auxiliary.

The primary duty of a physician is to care for the sick. To the layman this means prompt response by a physician when needed; therefore, support your emergency call service—organize your own district so that doctors are available day and night—convince the public that medical care is always available to them.

Reactivate immediately and efficiently your county public assistance program and see that it is properly supervised. We are committed to our promise to render the best medical care to all our people—the indigent as well as the prosperous, and we must see to it that a sufficient number of doctors in each community are available for this public welfare service.

Not the least of our profession's contribution to public welfare has been the organization and

support of our own non-profit voluntary insurance plan—the Medical Service Association of Pennsylvania—the Blue Shield. Its astounding growth has proved its worth and has made possible a recent increase in benefits to both physician and subscriber; likewise, the growth of similar plans over the nation at large has certainly confounded the proponents of compulsory insurance—at present they are confused but not amused.

Gentlemen, there are two fateful dates approaching on the calendar—dates which have to do with public welfare and our participation therein—dates of great importance to us as citizens and physicians, for on these days the people of your county, of your state, and of many other states go to the polls—May 16 and November 7. You have two paramount duties to perform: first, as individuals by personal contact with the candidates. Determine their attitude toward our problems having to do with true public welfare, and then discuss these attitudes with your friends and patients. This you can do only as individuals—we cannot legally do so as a unit of organized medicine. Second, see to it that you yourself, the members of your family, your friends and patients exercise their right of franchise. Our own record as physicians going to the polls is deplorable. You may be familiar with figures compiled in a city of a neighboring state following a recent election: 18 per cent of the physicians did not vote; 13 per cent were not registered and not eligible to vote. I beg of you, gentlemen, do not hang out the sign "Business as usual" on these dates. Care for the acutely ill to be sure, but don't schedule elective operations and don't make unnecessary appointments in your offices on these days; let the vitamin addicts wait until the next day for their shots. If you don't get to the polls, you may need a shot yourself the next day when you hear the returns. Work with your local ward or district committee—advise them of those whom you know may need transportation; vote yourself and help get out the vote; if this isn't public welfare, what is?

Any way in which we can improve our public relations is a contribution on our part to public welfare. We admit that many people really do not like us; some do not like us personally and some do not like us collectively as a profession. Perhaps in this regard we are not unique; even the clerical profession suffers—many clergymen are disliked personally, and the various religious faiths have their critics. It has been my lot to

travel considerably about this state and in other states the past two years and on many occasions I have (incognito) been an interested and embarrassed listener-in on conversations criticizing doctors and the medical profession in general. You know the nature of these gripes—excessive charges, wrong diagnosis, lack of service or attention, etc. Some perhaps are justified, but many are due to misunderstanding.

We have all come to realize that *not* all doctors will voluntarily be their own public relations representative. Because of their lack of foresight, and to protect the profession from the criticisms their deeds and activities arouse, we must set up the mechanism by which their dissatisfied patients—be the dissatisfaction real or imaginary—may be satisfied. Hence, the necessity for a setup to receive and consider grievances in each county society. Most of you are familiar with the Colorado plan, the gist of which is acceptance of complaints at the local level and passing them on up to the top state level if not adjudicated at the local level. Some such plan may be necessary in states of smaller populations and smaller medical societies. The mechanism of the plan is not at the moment important. I believe with the efficient structure of our county societies that we can handle this problem through our own executive committee and a judicial committee or a board of censors, with final reference, when necessary, to the district councilor and thence to the State Society's Board of Trustees or a committee thereof. It is possible that the House of Delegates of the AMA may, in June, present a master plan applicable to all states, and that our own House in October may make specific recommendation to the county societies. For the present, it is vitally important that you immediately set up a committee in your own society to consider properly the complaints that your county society secretary receives. Like it or not, we must not only give ear—we must

give action to those who have grievances. We must let the people of our communities know that we will listen to their complaints, be they justified or not, and that we will do something to satisfy them, letting the chips fall where they may, as a public service, to improve our public relations, and as another of our contributions to the public welfare.

Fellow members, of all of our society's activities which pertain to public welfare, I have directed your attention to but a few. Group activity in a committee, laying plans and prosecuting them to their culmination, is important to be sure. But much of this work has already been done. There remains uncompleted the most important and vital part of our role in public welfare, namely, your own personal, individual contact with your own patients in your own office and in their homes. How are they going to know and understand what we are doing for their benefit unless we tell them? How many of your diabetics know they owe their lives to a dog—that insulin therapy could not have been developed without animal experimentation—that our research workers have no use for their beautiful, blooded pets—that the dogs they want are the hungry, harried, dangerous, flea-infested mongrels that eke out a miserable existence robbing garbage cans in the alley? Who but you can make them understand this problem? Who but you can learn the attitude of candidates for office and advise your patients of the ones who are truly interested in public welfare and not just party politics? Are you too busily engaged in the practice of medicine to forget the art of medicine? Are you so busy that you cannot spend five minutes with each patient in your office or his home explaining to him the activities that we have just considered?

Gentlemen, if you are too busy, then our role in public welfare will not be fully achieved.

REGISTER TO VOTE!

It is extremely important that doctors and all voting-age members of their families be registered. Please do not neglect your duty as a citizen.

A Decalogue for the Early Diagnosis of Pelvic Cancer

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THE DIAGNOSTIC delay period in pelvic cancer of the female has been written about many times before. This discussion stresses particularly that phase of the delay period which involves the physician. The idea is to present the ten major etiologic factors of physician delay in early cancer diagnosis and to suggest means whereby the now prevalent delay period may be foreshortened.

The material for this discussion originates in the records of the Committee for the Study of Pelvic Cancer now functioning in the city of Philadelphia. The origin, development, and early accomplishments of this committee have been published previously and will not be detailed at this time.^{1, 2} Briefly it should be mentioned that in 1945 the Philadelphia Obstetrical Society formed the Pelvic Cancer Committee to study the delay period in the diagnosis of female pelvic carcinoma. The committee patterned its method of procedure to simulate the activity of the Maternal Welfare Committee. At monthly meetings, case histories obtained from questioning living patients with cancer of the female genital organs are reviewed. Physicians responsible for these patients during their illness are invited to participate in the discussion which is designed to disclose the cause of any existing delay and to bring forth remedial suggestions.

TABLE I

PROPORTIONS OF PATIENT AND PHYSICIAN DELAY IN 1580 CASES INVESTIGATED AS OF JULY 1, 1949

Patient delay	656	41.5%
Physician delay	230	14.6%
Physician and patient delay	234	14.8%
No delay	460	29.1%
Combined patient delay	656 plus 234	56.3%
Combined physician delay	230 plus 234	29.4%

The committee to date has detailed information on 1580 patients with pelvic cancer. Table I indicates the incidence of physician delay. A

total of 464 patients or 29.4 per cent had a delay of one month or longer before a final diagnosis of existing cancer was made. Twelve months was the average duration of the delay period for the entire group.

Through the discussion and analysis of these 464 case records two objectives have been attained. The first of these has been to ascertain the true causes of the diagnostic delay period. The second objective has been to pattern an approach to these factors whereby future delays might be avoided. The ten fundamental reasons for delay and their remedial counterparts form the subject of this paper. They are presented as "The Decalogue for the Early Diagnosis of Pelvic Cancer."

I. *History and Pelvic Examination: On the first visit take a careful history noting variations in menstruation, leukorrheal discharge, intermenstrual or postcoital bleeding, bloody discharge, abdominal pain, or irritation of the vulva. Perform a pelvic examination including the use of a speculum. Use a good light and examine the patient even if she is bleeding.*

The fundamental approach to any problem of diagnosis is the use of the physical examination and a careful recording of the history. The early diagnosis of pelvic cancer is no exception to this rule.

TABLE II

DELAY IN DIAGNOSIS DUE TO FAILURE TO EXAMINE PATIENTS

Organ	Physician		Number of Physicians Involved
	Delay	Not Examined	
Fundus	108	50—46.3%	105
Cervix	265	132—49.8%	270
Ovary	48	31—64.6%	58
Vulva	19	11—57.9%	21
	440	224—50.0%	454

The failure to perform a pelvic examination in the face of referable complaints is not an uncommon practice. Four hundred and forty pa-

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tients with cancer of the fundus uteri, the cervix, the ovary, and the vulva presented themselves to physicians because of pelvic complaints. No pelvic examination was performed in 224 or 50.9 per cent of these cases. It was noted further that these 224 patients visited some 454 physicians before being adequately examined. That many of these patients were not examined because of the presence of active bleeding indicates the fallacy of such a practice. No contraindication exists for performing a pelvic examination in the presence of vaginal bleeding.

No less important as a contributing factor to this subject of delayed cancer diagnosis is the failure to take a careful gynecologic history. In our series we have more than thirty patients who failed to mention bleeding or discharge as a complaint to their physician.

We strongly urge, therefore, that the first major step in this fight against pelvic cancer must be the employment of these two basic fundamental and age-old practices of taking a careful history and of making a thorough examination. It is difficult to see how these basic concepts of diagnosis will be replaced at any time, and it is the physician's responsibility to incorporate them in the handling of every patient.

II. *Biopsy of the Cervix*: Obtain an adequate biopsy in all lesions of the cervix that bleed or of simple erosions that do not heal following cauterization. Perform the biopsy by scalpel and include the important squamo-columnar junction of the portio and endocervix.

The more frequent use of the cervical biopsy before treatment of the diseased cervix is attempted might contribute materially to the problem of earlier cancer diagnosis. In the series of patients under discussion we note a total of 265 cases of cervical carcinoma in which a delay in diagnosis occurred. Of this number, 64 patients or 24.1 per cent had local treatment to a diseased cervix with no biopsy being attempted. The period during which local treatment was being carried out caused serious delay in diagnosis and in the institution of adequate therapy. These figures seem to indicate a need for more careful management of the diseased cervix.

III. *The Cervical Polyp*: Always precede a cervical polypectomy, including the base, with dilatation and curettage and biopsy of the cervix.

The Philadelphia group believes that this usually benign condition must be handled with respect. TeLinde³ states: "The finding of a cervical polyp, symptomatic or asymptomatic, is in-

dication for its removal and microscopic section." It is our opinion that the patient should not only have a polypectomy but should be anesthetized, the cervix dilated, and the fundus uteri curetted to be sure that the postcoital spotting or bloody discharge, as the case may be, was actually not coming from an accompanying undisclosed lesion.

IV. *Gross Pelvic Pathology*: Perform a pelvic examination on every patient who has unexplained abdominal symptoms, either with or without abnormal vaginal bleeding, to exclude ovarian cancer. Perform a dilatation and curettage and biopsy of the cervix in every case of abnormal vaginal bleeding or bloody discharge, even if associated with a demonstrable pelvic pathologic condition such as ovarian cyst or uterine fibroid.

In some 50 cases reviewed by the Pelvic Cancer Committee it was noted that unsuspected cancer was found in the pathologic specimen following surgery for lesions diagnosed preoperatively as benign pelvic tumors. In many of these instances supravaginal hysterectomy was performed for uterine myomata. The histologic examination of the specimen revealed an unsuspected and undiagnosed endometrial carcinoma. A diagnostic dilatation and curettage performed prior to the abdominal section might have disclosed the presence of the carcinoma. Such patients are deprived of the best known methods of treatment and consequently are less apt to be cured of their disease.

The frequency with which this occurs is somewhat startling. It is strongly recommended that all pelvic surgery be preceded by careful inspection of the cervix and a diagnostic curettage of the endometrium. This means an additional maneuver to the patient and adds a few minutes to the operative time, but how little this is compared to the importance of knowing whether or not the patient has a pelvic malignancy.

Any enlargement of the ovaries on pelvic examination must be considered with due respect. Ovarian carcinoma must be considered in all such instances. Such patients should be carefully followed and examined at frequent intervals for a change in the size of the tumor or change in symptoms. The early diagnosis of ovarian cancer is probably the most difficult of gynecologic problems.

V. *The Menopause*: Assume menopausal cycles to be normal only when the amount of bleeding and the frequency of occurrence of the

periods decrease or remain constant. Any variation from this, or any postmenopausal bleeding requires a diagnostic dilatation and curettage and biopsy of the cervix.

Certainly it would not be irregular to state that every patient at the menopause, with or without symptoms, should be examined. We note, however, that 75 patients who complained of abnormal vaginal bleeding were not examined internally. An additional 32 patients who had vaginal discharge but no bleeding were likewise not examined. This means a total of 107 postmenopausal women with early symptoms of pelvic cancer were not subjected to a pelvic examination. More startling perhaps is the fact that this means 45.1 per cent of the total 237 patients not examined in this series were postmenopausal.

It must be emphasized, too, that an adequate pelvic examination does not insure the diagnosis of pelvic cancer. We stress the examination as being the minimum effort we should make toward any diagnosis. Therefore, we emphatically add that any menopausal or postmenopausal patient with abnormal symptoms or signs must be further studied by a diagnostic dilatation and curettage and a careful evaluation of the uterine cervix. In some 33 instances the patients were bimanually examined and were explicitly told that no gross evidence of disease could be found "but that they should be watched because trouble might be developing." All 33 cases ultimately were found to have cancer, but not until after a delay period had occurred.

VI. Atrophic Lesions: Perform a dilatation and curettage and biopsy of the cervix in every case of bleeding or staining associated with "senile vaginitis." Examine carefully all lesions of the vulva and biopsy specimen prior to instituting treatment.

The sixth maxim evolved from the discovery that frequently at the monthly meetings of the Pelvic Cancer Committee the discussion centered on the elderly patient with minimal complaints. It was noticed in four instances that a pelvic examination revealed an atrophic senile type of vaginitis, and in all instances it was concluded that the complaint of pinkish watery discharge arose from the vaginitis. Uterine cancer was found some months later when more serious symptoms were noted and investigated.

A more common occurrence was the failure to proceed further when an attempted pelvic examination was unsatisfactory. An elderly nul-

liparous patient or the elderly spinster many times cannot be adequately examined because of the small caliber of the birth tract. Such patients with indicative symptoms should be thoroughly examined under anesthesia and subjected to diagnostic dilatation and curettage.

The atrophic lesions of the external genitals are important from the standpoint of early cancer diagnosis. In a previous report we noted that the average delay in diagnosis of vulvar cancer was 19 months. The use of local medications for periods of weeks or months as a therapeutic trial causes serious delay. Early biopsy and diagnostic efforts before treatment of any "sores" or surface irritations would improve this phase of our problem.

VII. Hormonal Therapy: Withhold all hormonal therapy for abnormal vaginal bleeding until a diagnostic dilatation and curettage and a biopsy of the cervix have been performed.

The simple rule that no hormones should be used until a definite diagnosis is established is logical and intelligent yet too seldom followed. Of the 237 patients referred to before who were not examined by their physicians, some 47 or 20 per cent of them received hormone treatment for their gynecologic complaints. Another group of 39 patients were examined pelvically but were not subjected to further necessary investigative procedures before the use of hormone therapy. In all we have 86 patients who received hormones orally or parenterally before a specific diagnosis was made.

VIII. X-ray and Radium Therapy: Never apply radium or roentgen therapy to the vulva, vagina, or other pelvic organs prior to examination, dilatation and curettage, and biopsy. Consider leukoplakia as a possible precursor of cancer requiring biopsy.

In 23 cases of cancer delay having vaginal bleeding, we note that x-ray or radium therapy was administered without a biopsy specimen being taken, without a diagnostic curettage, and in some instances even without a pelvic examination.

The common explanation given by physicians questioned for this approach to the problem was that if the irradiation failed to control the patient's symptoms, further investigative measures would be indicated. Pelvic cancer in most of its locations is so readily diagnosed if looked for and so easily accessible that any delay on this basis must be questioned.

IX. *Periodic Examinations and Careful Follow-up*: Advise all patients to have periodic pelvic examinations. Perform periodic pelvic and cytologic examinations (Papanicolaou smear) when indicated. Repeat the dilatation and curettage and biopsy of the cervix in those cases in which an original diagnostic dilatation and curettage and cervical biopsy failed to reveal histologic evidence of a malignancy but the abnormal symptoms persisted or recurred.

Patients who have had a diagnostic dilatation and curettage and/or cervical biopsy with no evidence of malignancy but with persistent symptoms should be carefully followed and subjected to repeat procedures when necessary.

The most practical and common-sense approach to early cancer diagnosis is the routine pelvic examination championed and popularized by Dr. Catharine Macfarlane⁴ of Philadelphia. It is suggested that after the age of 40 all female patients should have a pelvic examination every six months. Prior to this age an annual checkup may be sufficient. All physicians should start now to incorporate this program in their practices. I suggest with some temerity, yet with conviction of its value, that the physician send periodic notices to each patient every six months or annually as the case may be. I am aware of the criticisms of such a practice, but strongly feel that it is time to discard false prejudices and be practical.

A careful follow-up of the patients with suggestive pelvic conditions and symptoms is most important. In 33 instances in our records physicians indicated to patients the need for careful follow-up because of suggestive pelvic findings. Nevertheless in all of these cases there was a delay in time before a diagnosis of cancer was made. In many instances the delay was serious and probably contributed appreciably to the patients' ultimate demise.

Improper follow-up also has occurred in the best of hospitals and clinics. Many delays which result in institutions are the fault of no single individual but are due to the system used for the transference of patients from one department to another or from one institution to another. The

patient suspected of having cancer or the one known to have cancer must be so managed as to preclude the possibility of mismanagement or omission of early adequate treatment.

X. *Cancer Consciousness*: Keep the possibility of cancer always in mind when evaluating gynecologic symptoms.

If any single factor could be isolated as being the most common cause of delayed cancer diagnosis, it would be the lack of a reasonable awareness for the disease. Unless the physician is thinking of cancer as a possible cause of a patient's symptoms or pathologic condition, he will fail to make the diagnosis in early cases much less frequently than would otherwise occur.

The awareness for pelvic cancer may be difficult to cultivate and maintain by the general practitioner. In any single practice the occurrence of early gynecologic cancer is infrequent. It must be recognized, too, that in the early phases of pelvic cancer a diagnosis is often difficult to make. With the combined factors of infrequency of occurrence and the relative difficulty of early cancer diagnosis, it becomes increasingly obvious that only a keen suspicion or awareness of the possibility of cancer will bring about an increased incidence of early cancer diagnosis.

The decalogue for pelvic cancer as here outlined may influence the cancer consciousness of all of us and at the same time set up the minimum standards required to eradicate unnecessary delay in cancer diagnosis. Universal adoption of these minimum standards may not eliminate all of our problems, but if conscientiously practiced essentially will indicate that we, as physicians, are expending the utmost effort in accordance with our due responsibility to our patients.

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The Surgical Treatment of Pancreatic and Bile Duct Tumors

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THE SURGICAL attack on pancreatic and bile duct tumors is a story beginning in 1884 when it is reported by Mayo-Robson that Billroth resected the entire organ for carcinoma. Other isolated attempts were made in this direction in subsequent years and in the hands of other surgeons, but there were few successes. The most important of the early contributions was that of Codivilla who, in 1898, resected the head of the pancreas and the major portion of the duodenum. He re-established intestinal continuity with a Roux-type gastroenterostomy and joined the gallbladder to the jejunum over a Murphy button. This patient survived only 24 days, but the fundamental concept of our modern operation was established. In the same year Professor Halsted resected a carcinoma of the ampulla of Vater transduodenally. He removed a V-shaped segment of the duodenum with the terminal portions of the pancreatic and common ducts. The stumps of the latter were reimplanted into the duodenum. This patient was well for seven months, after which intervals the tumor recurred.

Dr. W. J. Mayo, in 1901, suggested a two-stage approach to tumors producing obstructive jaundice and performed preliminary cholecystostomy. In 1909 Kausch modified this to cholecystenterostomy. In 1908 Sauve conceived a two-stage operation which he performed on cadavers, and he expressed the view that reimplantation of the stump of the pancreas or its duct would be impossible. In 1914 Kerr suggested the capping of the cut end of the pancreas with the duodenum. This was first accomplished in 1922 by Tenani who preserved the external pancreatic secretion in a patient whose reported survival was three years. However, successes with these early attempts at radical pancreaticoduodenectomy, either for ampullary or pancreatic cancer, were so few and failures were so

numerous that Berkeley Moynihan wrote in 1905 that it appeared that the mechanical difficulties of the operation were well nigh insuperable and that, if boldness and good fortune were the operator's gifts, the result to the patient hardly justified the means.

Little progress was evident until 1935 when Whipple, Parsons, and Mullins reported their brilliant successes in two out of three patients using a two-stage procedure. In the first of these bile flow was re-established through a cholecystogastrostomy, the common duct was ligated, and a gastrojejunostomy was performed. At the second stage the patient was subjected to an excision en bloc of the second portion of the duodenum including the ampulla of Vater, the lower common duct, and the surrounding portion of the head of the pancreas. The pancreatic duct was ligated and the pancreatic stump closed. Of the two patients who survived, fatal cholangitis developed in one after eight months. Stimulated by Whipple's work, there was a revival of interest among surgeons in this problem of periampullary cancer. The contributions have been so numerous that no attempt will be made to name all of the contributors. Those operations which are deemed to have aided most in the simplification of the problem will be accented at this time.

It may be said that in the evolution of pancreaticoduodenectomy certain problems have obtained. Specifically, it is desirable to accomplish an en bloc excision of the neoplasm and its surrounding structures; to restore gastro-intestinal physiology to a state as near normal as possible; and finally to carry out this major undertaking in the simplest fashion available. Experience has established that ascending cholangitis occurs with great frequency when the gallbladder is anastomosed directly to the stomach or to a segment of intestine into which the stomach empties. In an effort to minimize this danger, Brunschwig in 1937 resorted to the use of a long jejunal loop

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for the gallbladder anastomosis. Cholangitis had been responsible for the death of one of Whipple's early cases, and in 1938 he performed a Roux-type cholecystenterostomy as a safeguard against infection in the biliary radicles. Occasionally it was found that the ligature placed around the common duct would cut through, producing a biliary fistula. This major complication is now avoided by direct anastomosis of the common duct into the bowel as in Trimble's operation. Such anastomosis also eliminates dependence on the small cystic duct whose channel is often inadequate.

Another important step in the development of our current concept of the operation is the abandonment where possible of the two-stage procedure. Unquestionably nutritional gains are to be anticipated if biliary obstruction can be relieved initially before undertaking the shocking excision of the duodenum and pancreatic head. It has been argued that with the two-stage procedure half of the operation has already been completed by the time the resection is undertaken and that the second procedure is correspondingly shorter. In my experience, I believe that it is apt to be prolonged. The biliary anastomosis is in the road and obscures the field. The advantages of the one-stage operation were evident to both Whipple and Trimble, each of whom performed it in 1941. Most operators now share this view. Exceptions do exist, as in those patients whose prothrombin level does not respond to vitamin K and who have considerable liver insufficiency. In them the operability of the tumor can be determined at an initial stage and a simple cholecysto- or choledochojejunostomy carried out. Most patients, however, can be prepared adequately for a single stage operation which permits the earlier eradication of the tumor, a technically easier operation, and the avoidance of the expense and risk of a second laparotomy.

Much has been written concerning the restoration of external pancreatic secretion into the intestinal tract. The incidence of fatty infiltration in the liver is well known when the pancreatic duct has been ligated. And in general it would appear desirable to preserve the normal functions of lipid metabolism rather than to depend on substitution therapy. This problem presents many technical difficulties. The posterior aspect of the pancreas is not covered with peritoneum, and the capsule of the gland is delicate and friable and not well adapted to suturing. The oper-

ations of Hunt and Whipple illustrate methods of capping the cut end of the pancreas with the stump of the bowel. More recently, and especially in the hands of Cattell and of Poth and of Reynolds and Pearse, a technique of anastomosing the duct of Wirsung has been developed. Up to 1943 Brunschwig preferred to eliminate the pancreatic anastomosis. In our hands the capping procedure alone has been used, and we have had difficulties with pancreatic fistulas. It is planned in the future to attempt the duct type of anastomosis over a stent or Blakemore tube. We are convinced that bile and pancreatic juice should be introduced into the intestinal tract proximal to the gastroenterostomy. In this position these strongly alkaline elements are available to protect the jejunum from marginal ulceration. This complication arose in one of our patients in whom total pancreatectomy had been performed for benign disease. In this same patient only a minimal gastric resection had been done. It is my feeling that a more radical resection of the stomach is indicated here just as it is in gastrectomy for peptic ulcer.

Obviously every suture line and every anastomosis represents a source of potential leakage, and every unnecessary step is time-consuming and adds appreciably to what at best is a lengthy operation. Gradually pancreaticoduodenectomy has been simplified to the point where only three anastomoses are necessary. Fewer than this are not possible. The operation of Waugh in our opinion best meets these requirements.

The high inoperability rate in periampullary cancer is readily understandable. These tumors commonly grow extensively and metastasize before clinical symptoms appear to lead to a diagnosis. In many instances the presenting symptoms are due to the metastases rather than to the primary lesion. Pain and weight loss often appear early. Jaundice is probably the most dependable symptom, and it may be intermittent. In general, bile duct and ampullary cancers grow at a slower rate and metastasize later than primary pancreatic tumors, and for this reason they carry a better prognosis. Occasionally the diagnosis may be made by x-ray. The clinical differentiation between carcinoma in the pancreas and chronic pancreatitis may be exceedingly difficult, as in one of our patients whose obstruction failed to improve after prolonged cholecystostomy. As in all malignancy early diagnosis is to be emphasized, and we heartily concur with Dr. Whipple

in his statement that jaundiced patients should not be "studied to death" before they reach the surgeon.

In the interval since the war my brother, Dr. James R. Watson, and I have encountered operable malignancy in the bile ducts, pancreas, or ampulla in five patients. On a sixth patient with chronic pancreatitis and obstructive jaundice, pancreaticoduodenectomy was performed under the impression that a malignant tumor lay in the pancreas. A seventh patient presented a small, localized carcinoma of the common hepatic duct treatable by excision and choledochoduodenos-

tomy. There were two postoperative deaths constituting a mortality of 28.6 per cent. One patient lived six months and another fifteen months before dying from a recurrence of the disease. One patient is living and well at eight months, another at seventeen months, and a third at twenty-four months. The resectability rate in the patients submitted to exploration has been low. For those patients in whom the spread of the tumor has made the resection operation impossible, palliative measures to relieve biliary and duodenal obstruction have given transient comfort.

VETERANS, BEWARE

If, as a veteran, you are planning to use the education rights under the G.I. Bill, the Veterans Administration has issued a regulation that you should study carefully.

The deadline for most veterans for starting a course of education or training is only twelve months away—July 25, 1951.

You can insure your eligibility for future years of postgraduate training by enrolling in the Graduate Education Institute sponsored by the Commission on Graduate Education of The Medical Society of the State of Pennsylvania.

The Veterans Administration regulation states that the majority of veterans will not be permitted to begin G.I. Bill courses after July 25, 1951. An exception has been made for those discharged after July 25, 1947, and those who enlisted or re-enlisted under the Armed Forces Voluntary Recruitment Act.

July 25, 1951, however, is not important to veterans who have started and actually are pursuing G.I. Bill training on that date, as they have the right to continue their courses.

The VA regulation explains that a veteran who has started a course and who has continued in it will be considered to be in training, even though he has temporarily interrupted the course for the summer vacation or for other reasons beyond his control.

Once a veteran completes or discontinues his program of G.I. Bill training after the 1951 date, he may not start another course.

The G.I. Bill provides that generally training must be initiated by July 25, 1951, or four years after a veteran's discharge, whichever is later, and it must be completed by July 25, 1956.

Most veterans are subject to the 1951 and 1956 cut-off dates, but there are the following exceptions:

1. Veterans discharged after July 25, 1947, have four years from date of discharge in which to begin G.I. Bill training. However, they must finish by July 25, 1956.

2. Veterans who enlisted or re-enlisted under the Armed Forces Voluntary Recruitment Act (between Oct. 6, 1945, and Oct. 5, 1946) are not bound by either

deadline. Instead, they have four years from the end of that enlistment or re-enlistment period in which to start, and nine years from that time in which to complete their course of training.

A veteran in either of these two categories actually must be in training when his individual entrance deadline comes around, in order to continue afterwards.

The VA regulation outlines requirements that veterans in training after the entrance cut-off date will have to meet.

They will be expected to pursue their training "continuously until completion, except for conditions which normally would cause interruption by any student."

They may change their educational objectives "only while in training and then for reasons satisfactory to the Administrator."

According to the regulations, satisfactory reasons for change are these:

1. When the veteran is not making satisfactory progress in his present course and the failure is not due to his own misconduct, his own neglect, or his own lack of application.

2. When the course to which he desires to change is more in keeping with his aptitude, previous education, training, or other such pertinent factors.

3. When the course to which he wants to change is a normal progression from his current course, and will help him attain his educational or vocational objective.

No additional changes of course will be approved, the regulation states, except for the most cogent reasons.

The VA regulation defines a course of education or training as a "curriculum, program of study or training or combination of subjects as are prescribed by the institution as constituting a course."

The following do not constitute a change of course: a change of one or more subjects within an elected curriculum or program; the dropping of a subject without replacing it with another; the adding of a subject; change in the sequence in which subjects are taken, or advancement from a basic or preparatory phase to an advanced phase of a course.

VA explained that it is issuing its regulations on deadline dates at this time in order to give veterans ample opportunity to make their plans for the future.

The Medical Aspects of Atomic Weapons

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THE DEVELOPMENT of the atomic bomb has imposed grave responsibilities on the medical profession. The hazards presented by the bomb open up a new field of medicine involving the diagnosis, prognosis, and treatment of internal and external radiation sickness, also the many problems incident to the detonation of the bomb or the military use of other radioactive agents.

There are several types of atomic bomb detonations. The first type of detonation is the air burst; this produces the greatest physical damage in the form of blast and heat. Many casualties will be caused from this immediate effect, and secondary casualties will be produced from falling and burning buildings and flying missiles. The ionizing radiation from this type of blast will also be of paramount importance in producing casualties. Contamination due to the settling out of fission products and unfissioned parts of the bomb will not be of great importance in producing radiation hazards if the bomb is detonated at a considerable height above the target. However, the lower the burst is to the ground, the greater this residual contamination will be.

With an underwater burst the physical damage is considerably reduced in magnitude, and the immediate ionizing radiation is also reduced. An underwater burst produces less physical damage, but since the bomb products are well mixed with water, a dangerous radioactive mist is formed which settles over a large area producing a dangerous hazard. Whereas in an air burst the radiation hazard is mainly from immediate external radiation, in an underwater burst the hazard is from both external and internal radiation caused from the radioactive mist and contaminated areas contaminated by the mist. This contamination is very difficult to remove. Decontamination can be effected for strategic struc-

tures or areas, but is difficult and time-consuming.

In addition to atomic bombing, one must also consider radiologic warfare in which a radioactive isotope or a group of radioactive isotopes are disseminated over a strategic area. This type produces a situation similar to an underwater burst.

The damaging effects of an atomic explosion are produced by heat, air blast, and radiant and ionizing energy. The thermal effect refers to the radiant energy of the atomic explosion and does not include the effects of secondary fires or explosions which may be the result of detonation. At the instant of the detonation, unmeasurable degrees of heat and light are produced. Both the infra-red and ultraviolet rays are capable of producing severe burns to the body surface, especially to exposed surfaces of the skin. The thermal energy, however, is of very short duration and although it may account for a high proportion of the casualties near the center of the detonation because of its extreme intensity, a relatively small amount of shielding offers considerable protection. Even light clothing, especially if it has a glossy surface, offers complete protection in many cases.

The primary type of air blast injuries are produced by the passage of the pressure wave through the tissues causing actual structural change and injury or death. Except for individuals in close proximity to the point of the burst, the primary effects are of little importance. At ranges where they might be considered dangerous, other factors would be of more importance as casualty producers.

The secondary air blast effect is far more important than the primary. Casualties are produced by (1) the structural collapse of buildings, (2) flying débris, and (3) the effect of being hurled against solid or semi-solid substances. All of these injuries would be essentially the same as those produced by any heavy air blast. The pri-

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mary air blast, moving at great speed from the immediate point of detonation of the bomb, produces a vacuum in a vast area. As soon as the spreading blast spends itself, the vacuum is replaced by air rushing in to fill the space. The returning wind is of great velocity and carries with it many of the solid objects loosened by the original blast effect. The flying missiles increase the number of casualties.

The recent introduction of atomic weapons as well as radioactive agents aroused a great interest in the biologic effects of the various forms of ionizing radiation and of neutrons. Individuals exposed to injurious dosages of these radiations present a variety of clinical conditions. Exposure of the external surface of the body to penetrating ionizing radiations and neutrons causes quite a different set of clinical findings from those caused by the injurious effects of internal body radiation.

Radiation sickness is the term used to describe the illness produced by overexposure to penetrating ionizing radiations and neutrons. Systemic reaction, in this instance, arises from exposure of the external surface of the body to penetrating radiation. Gamma rays, x-rays, and neutrons are the more common causative factors. The onset of symptoms may be abrupt or insidious. In the acute form, as observed at Hiroshima, it may be fulminating.

Radioactive poisoning is the term used to describe the illnesses which result from radioactive materials gaining access to the body. Here, they act as an internal poison producing localized or systemic effects or both. The offending radioactive poisons are materials which emit nuclear particles (alpha or beta) or nuclear radiations (gamma). Radioactive poisoning might occur from misuse of radioactive isotopes in attempted therapeutic procedures, from the dissemination of radioactive agents in warfare, or from the inhalation or ingestion of radioactive fission products from a nuclear explosion.

As far as the individual is concerned, there are certain intrinsic factors which determine the degree or pattern of cellular response to a given form and dosage of radiation. The lymph glands, the bone marrow, the testes, and the ovaries are the most sensitive organs. The hair follicles are more sensitive than the surrounding layers of skin. The brain is peculiarly resistant to radiation; the muscle tissue is somewhat less resistant.

For a given type of cell, the more immature it

is the more radiosensitive it tends to be. The most sensitive cells in decreasing order of sensitivity are lymphocytes, germinal cells of testes and ovaries, granulocytes, platelets, and erythrocytes. The formed elements within the circulating blood are slightly less sensitive than those within the hematopoietic tissues. As a consequence, cytologic blood studies provide the earliest and most reliable indices of the clinical state of any individual exposed to ionizing radiation.

The earliest blood changes following excessive radiation are leukopenia, severe anemia involving the red blood cells and the hemoglobin, and agranulocytosis. In grave excess it can lead to aplastic anemia and thrombocytopenia.

The biologic effect of large dosages of radiation is produced through the formation of ion pairs as a consequence of their effect on the protoplasm of the cells involved. It is likely that the processes of normal cellular metabolism are interfered with through the disruption of enzyme systems essential to the normal living of tissue. Cells may be killed or simply injured by ionizing radiation.

The genetic effects of ionizing radiation are variable. Such radiation can produce sterility as a primary effect, but no impotence. Impotence, when it occurs in connection with radiation, is a by-product of the various debilitating effects of severe radiation illness. Sterility is often temporary. Pregnant women who were victims of heavy dosage radiation in Japan did not bear monsters. Abortions and miscarriages were the result.

In considering the possible effects of ionizing radiation, one may be guided by the following table:

Exposure to:

10 to 25 r	Some injury likely, but probably not incapacitating.
100 to 300 r	Serious injury; some deaths practically certain but may be delayed.
300 to 600 r	Serious injury or death certain; very serious incapacitation; some may linger for weeks or months requiring extensive medical attention and even then die.
600 to 1000 r	Death certain, usually in first 24 hours.
Above 1000 r	Death certain, usually in a few hours.

In the evaluation of the symptomatology and progress of radiation sickness, it is safe to state that in the most severe cases death may occur within a few hours. Severe weakness and pros-

tration, a state of extreme shock, and a dulled sensorium with little else in the way of clinical or pathologic findings are characteristic of this group. There may be fever. The exact mechanism of injury and death in this type of case is not understood. The clinical picture, however, is clear-cut, and the prognosis completely bad. This type of severe exposure had rarely been seen in the human prior to the Hiroshima incident.

Individuals severely exposed, but not severely enough to die immediately, are likely to present varying degrees of shock, even within a few hours of the incident. Anorexia, nausea and vomiting, fever, and weakness with prostration may be the outstanding findings on the first day. There may be no evidence of skin injury. Pain and suffering are likely to be absent unless there is concomitant illness or injury. The sensorium is dulled and the individual is more likely to be apathetic than agitated. Death may occur on the second or third day. Blood counts taken a few hours after exposure may reveal a decrease in total leukocyte count and this decrease will invariably be noted on the second day. Before death, the count may drop to 500 cells or below. There may be a bothersome diarrhea beginning on the second day. This will become progressive if the individual survives beyond the second or third day. The diarrhea will gradually become very bloody. Late in the first week, secondary infection and a tendency to spontaneous bleeding will become serious complications.

In individuals who survive the first week the initial symptoms are not likely to be so severe or as early in their appearance. After the third or fourth day, a tendency to bleed may be an outstanding feature and may be an important factor in determining the outcome. Hemorrhage may occur into any organ or from any membrane. Bleeding from the mouth and gums, intestinal bleeding, and hematuria are to be expected.

During the latter part of the first week and thereafter, various forms of secondary bacterial invaders may complicate the picture. Due to the suppression of the lymphocytes and to the destruction of lymphoid tissue, there is a markedly decreased or completely absent resistance to infection. This may result in invasion of the intestinal mucosa by the normal intestinal flora, in bacteremia, boils and carbuncles, and ulceration of the tonsillar areas with marked necrosis of the laryngeal tissue. In cases of thermal burns or other skin injuries, the secondary infection

seriously delays healing and promotes the formation of scar tissue. This may become luxuriant and unique in its characteristics. This scar tissue resembles keloid and it is thought that it may in the future become malignant.

In a patient who survives the first week, there is very likely to be a profound anemia which will be the result of a combination of failure of the erythropoietic tissues and loss of blood. Both the red blood count and the hemoglobin will be reduced. In the more severe cases, there appears to be a complete paralysis of all marrow function and the clinical course and blood picture are similar to those found in fatal benzol poisoning.

The more severe the illness, the longer recovery is likely to require. In the casualty and death producing ranges of exposure, there is little individual variation and husky persons are not more resistant to the radiation than the less robust. However, in cases of less intensive exposure where secondary infection and hemorrhagic tendency are so common as to be considered an integral part of the clinical picture, constitutional endowment, age, and some secondary external factors may be of great importance in determining the outcome of an individual case.

Any individual who has received enough general body radiation to produce erythema is quite certain to die of acute radiation sickness. The hair follicles are much more sensitive to radiation than the skin, and it is possible for epilation to be produced by smaller, non-lethal doses. Epilation may occur prior to death in cases of fatal exposure when death occurs late in the illness.

In Japan, the peak of the death curve occurred during the third week and fell gradually until the sixth week. Those who survived the sixth week had a relatively good chance of recovery; most of the deaths subsequent to that time were caused by secondary infections and were attributable to the impossibility of asepsis and anti-sepsis under the conditions which existed there.

Occasionally, patients who have survived the first week of illness will be found to present an elevated leukocyte count as well as an increase in the hemoglobin and the total red cell count. The white blood count may be 15,000 to 25,000; the red blood count, 6 to 6.5 million; and the hemoglobin 110 to 125 per cent. In these instances the elevated white blood count is not necessarily evidence of infection.

Before considering any measures applicable in the treatment of casualties, one must contemplate

the probable havoc caused by an atomic explosion. In order to emphasize the magnitude of the problems of an atomic bomb detonation, let us for a moment compare it with the ordinary saturation type of bombing. In saturation bombing, a large number of planes with bombs are required to demolish a target area of perhaps one to two square miles. The destruction of homes, hospitals, and public buildings is generally avoided. With an atomic bomb, however, the detonation is equivalent to at least 20,000 tons of TNT and in a fraction of a second about ten to twelve square miles are demolished with no regard to buildings in the destruction zone. At the same time tremendous amounts of radiant and ionizing energy are immediately released. The instantaneous nature of such vast destruction creates a condition unparalleled in havoc and confusion.

At the present state of our knowledge, it may be safe to assume that one-third of the population of a bombed city will be killed outright or will die in days to weeks no matter how soon they are brought under medical care. Another third of the population will survive if medical care is quickly and adequately provided, and the remaining third have a fair chance of surviving without medical aid unless epidemics break out or unless disruption of transportation and other basic facilities makes it impossible to provide food, water, and shelter.

The responsibilities imposed upon the physician at such a time are stupendous. The rescuing, handling, and treatment of tremendous numbers of casualties make this one of the most imposing problems to be faced. The presence of contamination may interfere with the rescue of survivors and contaminate large numbers of refugees who in turn may carry radioactive materials outside of the bomb area into uncontaminated regions. Food and water supplies may be contaminated. Large numbers of refugees will have to be cared for; unsanitary conditions and lowered resistance to infections may produce large epidemics of disease.

In order to mitigate these factors and decrease panic, it is essential that civilian and military organizations carefully draw up disaster plans to handle any such eventuality. It is also very important that everyone be educated and trained in certain phases of this problem. It is pertinent to remark that it requires three to five years to establish a well-integrated nation-wide civil de-

fense organization. None functioned in Japan or in Germany during the last war.

The present-day concept of treatment of casualties resulting from the various manifestations of nuclear explosions is the prompt administration of whole blood and antibiotics. However, early treatment of survivors is likely to be impossible because of the difficulty of getting to the bomb victims, the probable lack of functioning medical facility, and the lack of availability of trained personnel and of proper instruments and material.

Measures to Be Applied in the Field Before Removing the Casualty:

1. Do not needlessly expose rescue or aid party personnel to grave external radiation hazards. Do not attempt to remove patients to a "clean" area for treatment until decontamination has been accomplished to a safe degree.

2. Protect against shock and administer simple life-saving measures to acute cases where such are indicated and the situation permits.

3. Transport to proper aid station or hospitals as soon as possible. Do not attempt transfusions or intravenous procedures forward of the aid station.

Measures to Be Applied in the Aid Station:

1. Continue to protect against shock.

2. Furnish general medical care indicated by the situation.

3. Select for whole blood transfusions only those cases in which medical judgment would indicate that some benefit could be derived. In cases which have obviously received massive doses of radiation, transfusion and heroic treatment are *not* indicated. These casualties must be left to die. Decisions will be difficult to make, but in case of an atomic disaster it is most probable that trained personnel and all material (including whole blood) will have to be rigidly rationed, conserved, and expended only on those who have a reasonable expectance of recovery.

4. If possible on the second day, select cases for further intensive care on the basis of white cell counts providing other hopeless findings are not overriding. If a patient has less than 2000 white cells, he should not be further transfused. If the count is above 2000, he should be selected not only for transfusion but for the best medical and nursing care that it is possible to provide. If, on the third day, the count has increased to 5000, the chances of recovery are good, but if there has been a further decrease, the chances of

recovery are nil and no further expenditure of critical supplies is warranted.

General Considerations Applicable After the Second Day:

1. Provide good nursing care, asepsis, and antisepsis.

a. Hygiene of the mouth and skin.

b. Avoidance of parenteral treatments if possible.

2. Penicillin and sulfonamide medication, orally if possible.

3. Streptomycin in cases of *B. coli* invasion or bacteremia.

4. Whole blood transfusions as indicated by blood studies.

5. Folic acid and liver extract to support the transfusions.

Any organization planning to cope with an urban disaster will have many important factors to contend with. For example, the destruction will be of such a scale that no help from the city itself or its inhabitants can be expected. Evacuation of a population amounting to hundreds of thousands must be planned for. There may be no possibility of entering portions of the devastated area for rescue work, fire fighting, etc. None of the existing protective agencies of the involved city will be capable of functioning in view of our present types of building construction. Only those hospitals in outlying districts could be used. Medical stores as presently distributed would be inaccessible or useless.

In view of these factors, a nation-wide organ-

ization for meeting the impact of such a disaster is imperative. Such an organization should be non-military and should include all of the nation-wide and state-wide organizations such as the United States Public Health Service, the American Medical Association, the American Red Cross, the state police forces, etc.

Adequate provision must be made for the detection and marking of potentially dangerous radioactive areas. For several weeks, the services of several thousand doctors would be required to render more than rudimentary first aid. Thousands of pints of blood would have to be immediately available and judiciously used to insure the saving of lives which would otherwise be lost. The housing problem would be virtually insurmountable.

In addition to the above general considerations, there are certain specific points which should be given careful consideration. The matter of transportation and communication is of prime importance. Inter-city communication by rail and roads should be markedly improved with maximum avoidance of congested areas. This is especially important in the case of roads. Divided traffic lanes are essential. The principle of dispersion should be applied as widely as possible.

Provision should be made at or near the periphery of all large centers of population for adequate underground storage of essential supplies and equipment. The collection of blood, blood derivatives, and other vital supplies in the center of any city will make such stores inaccessible following this type of disaster.

UNITED FRONT

In its fight to prevent the creeping paralysis that is socialism, as it is pin-pointed in plans to foster compulsory health insurance, the medical profession has found it necessary to undertake civic and political action, which a few years ago was remote from the thoughts of most physicians.

Around the medical profession have rallied those forces of the nation that treasure freedom and stand firm against regimentation and compulsion by any central governmental agency.

Great civic responsibility rests on the medical profession as a result of such action, responsibility as deep and wide as the traditional responsibility of the individual physician for the individual patient.

It may be difficult for some physicians to recognize completely what the new civic responsibility of the pro-

fession entails. Some physicians forget that strong opposing opinions of individual doctors, and the resulting argument within the family of medicine, are now watched closely by the rest of the nation and sometimes misunderstood.

To measure up to the new civic responsibility of the medical profession, a united front must be maintained so that the public will not think, erroneously, that any private differences over techniques of accomplishing the mission represent fumbling, hesitancy, and lack of certainty over the goal to be attained.

Of the goal, there is no doubt—to attain the highest quality of medical care for the greatest number at the lowest cost and without lowering medical standards, and without taking the retrogressive step of adopting regimented socialized medicine.—*New York Medicine*, June 20, 1950.

Clinical Syndrome of Hyperpotassemia and Hypopotassemia

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ALTERATIONS in the serum potassium have assumed considerable importance in the past few years because of the recognition of the number of conditions in which alterations in this electrolyte occur; the serious disturbances that occur in the body when the serum potassium is abnormally high or abnormally low; the rather characteristic alterations that this electrolyte produces in the electrocardiogram; and the complete reversibility of the changes when the serum potassium returns to normal.

Hyperpotassemia

Hyperpotassemia has been observed clinically in azotemia, Addison's disease, diabetic acidosis, and following the administration of potassium, particularly to patients with renal damage. The effect of hyperpotassemia on the organism has been studied in detail in the experimental animal. The correlation of the electrocardiographic changes with the level of the potassium in the serum was first reported by Winkler, Hoff, and Smith. They observed that alterations in the T wave regularly appeared at concentrations of 5 to 7 mM. per liter, depression of the S-T segment appeared at 8 to 10 mM. per liter, the P waves disappeared at 9 to 11, and cardiac arrest took place at 14 to 16 mM. per liter. Examples of hyperpotassemia, some with fatal effects, have been reported in the human subject. These have usually been observed in the presence of marked renal damage and the electrocardiogram has shown findings similar to those observed in dogs, namely, widening of the ventricular complexes with a slow idioventricular rhythm and sinoauricular heart block. Deaths have been reported at serum concentrations ranging from 8 to 12 mEq. per liter.

The presence of hyperpotassemia may be suspected in the presence of one of the conditions

mentioned above, by the electrocardiographic findings, and corroborated by chemical study.

The treatment of hyperpotassemia is that of the underlying cause. The serum potassium may be decreased in some instances by the administration of calcium, by glucose, which tends to promote diuresis and results in a shift of potassium from the serum into the cells during the process of glycogenesis, and by the use of a dialyzing apparatus, particularly in patients with azotemia.

Functions of Potassium in the Body: This electrolyte is intimately connected with the contractile process. Potassium is essential for normal muscular function. Muscular activity results in loss of potassium. A low potassium results in weakness, poor muscle tone, paralysis, and ultimately, death. Smith¹ has observed that various muscle groups became paralyzed in dogs which were fed on a diet low in potassium, and unless potassium was administered, there was a state of collapse and death. Deficiency of body potassium has resulted in necrosis of heart muscle in the experimental animal.

Potassium is essential also for normal nerve function, particularly in the neuromuscular transmission of the impulse. It acts in initiating the excitation process. Potassium also has a pressor effect which resembles that of epinephrine. The pressor effect is the result of the following mechanisms: a central action, a peripheral effect on blood vessels, a stimulating effect on epinephrine secretion, and probably an increase of vascular muscle tone.

Potassium is important for normal carbohydrate metabolism. Fenn demonstrated that the deposition of glycogen in the liver could not take place unless accompanied by a certain amount of potassium. He believed that this may be true for the deposition of glycogen in muscle as well as in the liver. Several investigators have postulated that potassium is essential for the formation of phosphorylated carbohydrates with-

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in the muscle cell. It has been presumed that it acts as a catalyst in such reactions promoting esterification of the inorganic phosphorus, the first step in the synthesis or breakdown of glycogen.

Hypopotassemia

Clinical States Associated with Potassium Deficiency: Low concentrations of potassium in the serum and diminution in cellular potassium have been observed in the following conditions: (1) diminished intake of potassium; (2) in animals and patients treated with large doses of desoxycorticosterone; (3) administration of testosterone, adrenocortical extract, and estrogens; (4) diabetic acidosis; (5) Cushing's syndrome; (6) fluid loss in intestinal obstruction; (7) diarrhea, and (8) renal disease.

Cardiac Effects of Hypopotassemia: The following cardiac effects during hypopotassemia have been noted: dilatation of the heart, the development of systolic murmurs, ectopic rhythms, and profound electrocardiographic changes of a type associated with severe grades of myocardial abnormalities. In addition, the blood pressure is usually low. Such profound effects on the heart obviously add to the severity of the clinical picture. These alterations are usually promptly reversed by the administration of potassium.

Electrocardiographic Changes Associated with Low Serum Potassium: The electrocardiographic alterations associated with a low serum potassium have received relatively little study. In 1937 Bellet and Dyer³ reported characteristic electrocardiographic changes in 23 patients after their emergence from diabetic acidosis. These changes consisted of a lengthening of the Q-T interval, depression of the S-T segment, and, in some instances, inversion of the T waves. The relation of these changes to hypopotassemia was not established originally. However, the relationship of characteristic electrocardiographic changes in hypopotassemia and in diabetic acidosis has been well established by the more recent studies of Holler,⁴ Branning and Nicholson,⁷ Martin and Wertman,⁵ and Nadler, Bellet, and Lanning.⁶

Hypopotassemia as a cause of characteristic electrocardiographic changes was first established in studies of patients with familial periodic paralysis (1940-41). In addition, Thomas (1939) published records of a case of Addison's disease in which hypopotassemia resulted from the administration of desoxycorticosterone acetate. A similar case, but without serum potas-

sium values, was published by Currens and White. Brown, Currens, and Marchand⁹ reported the occurrence of muscular paralysis in chronic nephritis in two patients owing to potassium loss. Serum potassium values were not made. Ellis¹⁰ reported the electrocardiograms of four prisoners of war suffering from severe malnutrition and diarrhea. The electrocardiographic changes closely resembled those of low potassium, although other factors were probably operative.

In our experience with 400 electrocardiographic and serum estimations of hypopotassemia in 91 patients with various etiologies, we observed the following electrocardiographic patterns: (1) prolongation of the Q-T interval accompanied by depression of the S-T segment of varying degrees; (2) inversion of the T waves accompanied by S-T segment depression, without S-T segment depression and a so-called beaked T wave; (3) somewhat flattened T waves or T waves of small amplitude followed by a U wave, and (4) lengthening of the entire Q-T interval, accompanied by an upright T wave of normal amplitude. These T wave changes were often followed by U waves of varying degrees of prominence.

Although various patterns described above were observed, the most consistent single finding was prolongation of the Q-T segment. All of these changes were immediately reversible following administration of potassium.

Mechanism of Potassium Loss in Diabetic Acidosis: The body potassium is diminished in diabetic acidosis by the following mechanisms: (1) lack of intake of food, (2) vomiting, (3) dehydration, and (4) the increased elimination in the urine. The serum potassium, which is normal or high upon the patient's admission in diabetic acidosis, drops to a hypopotassium level within three to twelve hours following therapy. This hypopotassium level is maintained until the patient is either given potassium parenterally or is able to take food by mouth. The degree of hypopotassemia depends upon the previous state of the potassium depletion and the amount of insulin, glucose, and fluids administered. In some instances the typical syndrome of hypopotassemia with flaccid muscular paralysis has been observed.

Mechanisms of Potassium Loss Through Vomiting Due to Intestinal Obstruction: Potassium is lost in intestinal obstruction mainly

through the direct loss of the electrolyte which is present in the stomach and intestinal secretions. Falconer¹¹ and others observed that the vomitus contained five times the concentration of potassium that is present in the serum. With the loss of gastric secretions, more chloride is lost than sodium, with the resulting production of alkalosis.

A loss of potassium may also result through procedures designed to treat the vomiting and certain other symptoms caused by intestinal obstruction. Suction by the Wangenstein or Miller-Abbott tube results in a loss of considerable amounts of fluid which carries away with it quite large amounts of potassium.

The parenteral administration of glucose tends to diminish the serum potassium by driving the potassium into the cells of the muscles and liver. This is particularly apt to occur when the cellular potassium is low. In addition, glucose tends to produce a transient depletion of salt and helps to eliminate potassium by stimulating diuresis. On the other hand, glucose has a sparing effect on protein loss which occurs when the patient is not taking food by mouth. Since protein and potassium are present in the cell in the ratio of protein 2 Gm. to potassium 1 mM., the sparing action of glucose on protein would tend to prevent loss of nitrogen and, to this extent, to diminish potassium loss from the body.

Tarail and Elkinton¹² have shown that one of the major factors in the development of deficits of potassium in those patients appears to be the continued excretion of potassium by the kidney during periods of restricted ingestion of this ion. They have shown, in some patients, losses of as much as 41 mEq. per day in gastric secretions. However, usually more potassium is lost in the urine than in the gastro-intestinal fluid. More potassium appeared in the urine when the serum concentrations were low than when it was at higher levels.

Hypokalemia in Other Conditions: The stools in severe diarrhea contain large quantities of potassium which come chiefly from the intracellular compartment. A low serum potassium has been found in cases of sprue.

Increased renal excretion of potassium occurs following the administration of desoxycorticosterone, and to a lesser degree following the administration of adrenal cortical extract, testosterone, and estrogens. Increased excretion of potassium apparently also occurs in the alkalosis of Cushing's syndrome.

Although the mechanism for the production of hypokalemia in familial periodic paralysis has not been definitely established, it is believed to be based on a disturbance of potassium metabolism. This condition is often activated clinically by excessive carbohydrate metabolism. The defect apparently depends upon an unexplained natural deficiency of potassium in the liver and other tissues; upon an unexplained increased requirement for potassium in certain aspects of carbohydrate metabolism; or upon a change in cellular permeability to potassium or other cations.

Recognition of Potassium Deficiency: The diagnosis of potassium deficiency depends upon: (1) recognition of the conditions likely to be associated with this disturbance as mentioned above; (2) the presence of muscular weakness and atonic muscles and occasionally muscular paralysis; (3) characteristic electrocardiographic changes which return to normal when potassium is given, and (4) confirmation by chemical determination of the serum potassium. Particularly important is an estimation of the loss of body potassium by measurement of the retention of this electrolyte during the state of recovery.

Effect of Administration of Potassium: Potassium chloride in a form of a 1.14 per cent (isotonic solution) was administered to 30 patients with hypokalemia intravenously in a dose of 500 to 1000 cc. in a period of two to six hours. This electrolyte was also given by clysis and, in a few instances, by mouth. Following the injection, the patients showed evidence of clinical improvement as manifested by diminished weakness and a sense of well-being. The blood pressure, usually low prior to injection, often rose 30 to 40 mm. after potassium had been given. The diastolic pressure usually increased more than the systolic. The improvement was temporary unless the cause of the potassium deficit was removed or the patient began to take food by mouth. Following the injection of potassium, the electrocardiographic changes observed during hypokalemia tended to return to normal as the serum level approached a normal value.

Therapeutic Implications: The above findings indicate that potassium should be included in the parenteral fluids used in those states associated with vomiting due to the deficit in potassium. Darrow¹³ suggests that the solution used to replace the electrolyte deficit should contain so-

dium chloride, sodium bicarbonate, and potassium chloride when acidosis is present. In alkalosis, on the other hand, a solution containing sodium chloride and potassium chloride is indicated. The importance of establishing and maintaining a normal electrolyte balance cannot be overemphasized. The intravenous route can be used in patients who are in some degree of shock and in the presence of diabetic acidosis. In other instances, intravenous injection is usually associated with more or less severe pain at the injection site which renders its administration difficult. Administration by clysis is usually associated with no discomfort; administration by mouth can be resorted to where feasible.

Toxicity of Potassium: A discussion of the toxic effects of potassium is of importance because the therapeutic indications are to supply potassium in large quantities to overcome the potassium deficit. Potassium chloride has been given by mouth in doses from 5 to 15 Gm. without untoward effect to patients with normal renal function. Most of the potassium is eliminated in a period of three to four hours. The toxicity following parenteral injection depends upon the rapidity and the amount injected, the potassium level prior to injection, the renal function, and probably the condition of the heart at the time of injection. In man, in the absence of potassium deficit, the maximum amount considered safe to inject intravenously at one dose is only 3 to 4 mg. per kg. of body weight. The chief danger in the use of potassium salts is the production of heart block. This develops when the extracellular concentration rises to a little more than twice the normal value. If renal function is good, potassium is rapidly excreted when the concentration in serum rises. However, rapid intravenous administration can exceed the rate of excretion. Darrow has estimated that 3.5 mM. of potassium or 0.26 Gm. of potassium chloride per kg. is a safe dose if used with proper precautions. The total dose should not be given in less than four hours and preferably should be given by slow drip in eight or more hours. For parenteral administration, he suggests its administration by hypodermoclysis since this method is safer than the intravenous route. The administration of potassium chloride should be combined with sodium chloride or sodium chloride and sodium bicarbonate together with intravenous glucose in water sufficient to supply the water requirement. The glucose probably facilitates the transfer of potassium to the cells.

In the patients of our series, all of whom had low levels of serum potassium and probably low cellular potassium, we injected quantities from 500 to 1000 cc. of a 1.14 solution without untoward effect in a period of two to six hours. Our experience would seem to indicate that patients in a depleted state of potassium can tolerate large quantities without untoward effects. In case of doubt, it is suggested that the injections be given slowly and that frequent electrocardiographic checks be made before additional quantities are administered. It is believed that the dangers of potassium intoxication have been considerably overrated.

There are two conditions in which the administration of potassium might be dangerous: (1) in the presence of renal damage, and (2) in the presence of severe myocardial damage. With renal azotemia, a retention of potassium occurs in the body and may attain toxic levels in the serum. The exact point at which the serum levels may be considered toxic or lethal has not been definitely determined in the human. Deaths have been reported with serum concentrations of 8 mEq./liter, but recovery has been reported when the concentration has been over 12 mEq./liter. While we would consider that the presence of renal azotemia is an absolute contraindication to potassium administration, we are not so certain that the same is true in patients who have pre-renal azotemia associated with a low serum potassium as is not infrequently observed in dehydration states. In such patients the administration of potassium cautiously may be of help.

It has been recently shown in our laboratory that the toxic level of serum potassium is modified by the cardiac state. In dogs with severe grades of acute myocardial infarction, the toxic levels and the serum level at death were significantly below those observed in normal control animals or where the degree of myocardial infarction was slight or in a healed state.

Summary

The clinical syndrome of hyperpotassemia and hypopotassemia is discussed. Hyperpotassemia is observed much less frequently than hypopotassemia. The functions of potassium in the body, particularly its relationship to normal muscular function, transmission of nerve impulse, and carbohydrate metabolism, are discussed.

The various conditions associated with hypopotassemia include chiefly those associated with

fluid loss, e.g., vomiting and diarrhea and the administration of desoxycorticosterone and other adrenal hormones.

The cardiac effects of hypopotassemia are rather marked and are characterized by cardiac dilatation, systolic murmurs, hypotension, and profound electrocardiographic alterations.

The electrocardiographic patterns in hypopotassemia include lengthening of the Q-T interval, depression of the S-T segment and of the T wave, and inversion of the T waves. The electrocardiogram is a somewhat rough but dependable criterion for following potassium values.

The mechanisms of potassium loss in diabetic acidosis, vomiting, and other states are discussed.

The administration of potassium to patients with hypopotassemia resulted in clinical improvement and a return of the electrocardiogram to normal. Administration of this electrolyte in such states is important and in some patients may be life-saving.

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"BEST-KEPT SECRET"

Newsweek magazine recently asked "Can we finance a welfare state without tumbling into socialism? Are taxes killing our economic growth?"

The magazine's business editor makes a detailed report in answer to these questions. Excerpts from it reprinted below will have great significance for the doctor of medicine who must face the fact that socialism—not just socialized medicine—is the problem facing the United States today:

"Not one American in a hundred realizes that total tax collections now exceed the wartime peak. And not one in a thousand knows that hidden taxes—included in the price of everything he buys—will exceed \$700 per family this year. In fact, the best-kept secret in the country today is the size of the tax load.

"In 1945, when the United States was fighting a global war with 11 million men under arms, Federal, state, and local governments collected 52½ billion dollars in taxes. This year they are skinning off 55 billions—25 per cent of the national income and more than the entire national income in 1932, 1933, or 1934.

"To a modern Rip Van Winkle, rousing from a twenty-year snooze, the sight of the Federal government alone spending 43½ billion dollars a year would be unbelievable. In 1929 the total U. S. budget was about three billion dollars. The government spent an amount less than two-thirds of the personal income of

the residents of California. Last year Federal expenditures were roughly equal to the entire income of all persons west of the Mississippi."—*Journal of the Oklahoma State Medical Association*, June, 1950.

RESEARCH FELLOWSHIPS

The American College of Physicians announces that a limited number of fellowships in medicine will be available from July 1, 1951 to June 30, 1952. These fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The stipend will be from \$2,200 to \$3,200.

Application forms will be supplied on request to the American College of Physicians, 4200 Pine St., Philadelphia 4, Pa., and must be submitted in duplicate not later than Oct. 1, 1950. Announcement of awards will be made in November, 1950.

The Diagnostic Problems of Gross Hemorrhage from the Upper Gastro-intestinal Tract

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GROSS hemorrhage from the gastro-intestinal tract is one of the more dramatic emergencies encountered in the practice of medicine. Because bleeding of this type often occurs without warning and without antecedent symptoms, and since its severity often prevents prompt investigation by means of detailed procedures, the physician is frequently faced with the need for planning therapy before he has determined the exact source and cause of the hemorrhage. The purpose of this paper is to review the general diagnostic problems presented by massive hemorrhage from the upper gastro-intestinal tract and the methods by which its causes may be recognized.

Bleeding from the upper gastro-intestinal tract presents diagnostic problems quite different from and often more difficult to solve than those associated with bleeding from the colon and rectum. It seems advisable to limit myself to a discussion of hemorrhage from the lower esophagus, stomach and duodenum, and small intestine. The subject will be further restricted to a consideration of gross hemorrhage—bleeding that is sufficiently severe to cause recognizable hematemesis or melena. Many of the lesions capable of causing large hemorrhages do, of course, occasionally produce slow and protracted bleeding, which acquires clinical significance with the development of marked secondary anemia. The restriction of this discussion to gross hemorrhage is not intended to minimize the importance of this slower type of bleeding. I desire, however, to emphasize the fact that the catastrophic nature of massive and sudden hemorrhage often places the physician under diagnostic difficulties that do not exist when the bleeding is a slower process.

It is the common practice to discuss hematemesis and melena together. This is logical since, although these two manifestations of gastro-intestinal bleeding may appear independently of each other, they so frequently occur together. Only rarely is hematemesis not followed by the passage of sufficient blood down the bowel to cause recognizable discoloration of the stool (melena). Melena, on the other hand, may and frequently does occur without any blood having been vomited. This is particularly true, of course, when the bleeding arises in the duodenum or from some other point distal to the pylorus. The same lesion—a peptic ulcer is the best example—may cause only melena on one occasion but produce both massive hematemesis and melena on another. Because of these facts, and because the diagnostic and therapeutic problems which these two symptoms present are the same, it seems best to continue to consider hematemesis and melena as closely associated phenomena and due to the same general causes. Whether bleeding into the upper gastro-intestinal tract will lead to melena alone or to both hematemesis and melena will depend upon the location of the bleeding point and also upon the amount of blood lost and the acuteness of the hemorrhage. Melena may result from small hemorrhages. It has been demonstrated (Daniel and Egan) that the introduction of as little as 50 cubic centimeters of blood into the stomach may produce a tarry stool. All physicians have seen instances in which patients have passed single tarry stools and have had no other immediate symptoms of active gastro-intestinal disease. These are probably the result of losses of, at most, a few hundred cubic centimeters of blood. Determination of the sources of these small hemorrhages is often extremely difficult.

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The Principal Causes of Hemorrhage

Complete lists of all the diseases which may cause hemorrhage from the upper gastro-intestinal tract can be found in standard textbooks of gastroenterology. Examination of such lists will show that bleeding may be the result of a great variety of lesions. It is well known, however, that many rare lesions are included in such lists for the sake of completeness. A relatively small number of disorders are responsible for the great majority of hemorrhages. When one names peptic ulcer (including gastric, duodenal, and post-operative ulcers), gastritis, gastric tumors (benign and malignant), esophageal hiatal hernias, esophageal varices due to cirrhosis of the liver, and small bowel tumors, one has named the lesions which cause almost all of the hemorrhages from the upper gastro-intestinal tract. Even this small list, however, contains lesions which are relatively uncommon causes of massive bleeding. It could be shortened further by stating that peptic ulcer, gastritis, and esophageal varices are not only the three most common causes of massive hemorrhage but that they cause between 80 and 85 per cent of gross bleeding.

Statistics of this type, however, may be somewhat misleading and there are striking differences in the figures reported by those who have reported upon series of patients with hemorrhage. Like all statistics, these form but a general guide to the problem and may be of little help in the recognition of the cause of bleeding in an individual patient. It is true, unfortunately, that bleeding is occasionally the result of a rare and unusual disease. It must be stated also that the demonstration of an obvious lesion, such as an ulcer or hiatal hernia, does not necessarily prove that this was the source of a recent hemorrhage. The problem is further complicated by the fact that in a definite number of patients the cause of a hemorrhage may remain undiscovered despite careful and thorough search. The physician must plan, therefore, for an intensive and comprehensive study of each patient who suffers a massive hemorrhage so that nothing which may be responsible will be missed. Statistics are valuable in indicating those lesions which are most frequently found to be the causes of hemorrhages so that these may receive early diagnostic consideration. The fact that a small group of diseases causes such a large proportion of all hemorrhages does not, however, exempt us from searching for other sources of bleeding, even though these may be rare.

The general problem of the diagnosis of massive gastro-intestinal bleeding is a multiple one and presents numerous facets. An initial step is to determine, if possible, whether an ulcer is present since this is certainly the commonest lesion to be found. If the presence of ulcer cannot be established readily, thought must be given to a non-ulcer cause for the bleeding, such as gastritis or some type of tumor. Prompt consideration must also be given to ruptured esophageal varix, particularly since the introduction of methods designed to control a bleeding varix by local compression of the ruptured vein. If the cause of the hemorrhage is not fairly obvious, the physician must plan those detailed studies—x-ray examinations, laboratory tests, and endoscopic procedures—which may permit a specific diagnosis, and decide upon the safest time to do these. In all of the diagnostic activities the doctor must be guided by the clinical status of the patient. The treatment of shock must, of course, precede any strenuous examination or one which may initiate further bleeding.

The Diagnostic Value of the Patient's History

As in all attempts to establish a correct diagnosis, a detailed history is the first requirement. Unfortunately, however, hemorrhage is often an initial symptom and there is no antecedent history to serve as a guide to its cause. In addition, the patient is frequently too ill to undergo close questioning and the history must be taken from family or from friends. When obtainable, however, a few facts about previous symptoms may prove extremely valuable. A typical history of recurring episodes of post-meal pain with characteristic food or antacid relief goes far toward indicating ulcer to be the cause of the bleeding. It is fairly common to find that these symptoms have been present for a short period prior to the hemorrhage but have disappeared as soon as the bleeding began. In an appreciable number of patients, however, the hemorrhage is the first sign of ulcer disease. It is estimated that 25 per cent of patients who bleed from ulcer have no typical digestive distress prior to the initial hemorrhage (Bockus). Eusterman and Morlock found hemorrhage to be a "painless, almost exclusive feature in 18.5 per cent of bleeding ulcers." These authors also described patients in whom hemorrhage was considered to be the first manifestation of ulcer that did not produce other symptoms until months or years had elapsed. One may question whether a diagnosis of ulcer is jus-

tified in all of these patients who bleed without other symptoms of digestive difficulty. Such a diagnosis is probably correct in most young men, at least in those whose hemorrhages occur in this manner. Certainly every consideration must be given to the possible presence of ulcer, both in the studies to be done immediately after the hemorrhage and in subsequent continued investigation of the patient if these studies are negative. It must be noted, however, that in many cases of so-called silent bleeding the initial diagnosis of ulcer is never confirmed.

A history of previous hemorrhage may have various diagnostic implications. If these hemorrhages have occurred in a patient who has had periodically recurring rhythmic pain, ulcer is certainly the outstanding possible cause. Likewise, a history of a previous gastric operation, a resection or gastro-enterostomy, points strongly to recurrent or anastomotic ulcer, as the probable cause of hemorrhage. On the other hand, repeated episodes of bleeding over a period of years in a patient who has never had digestive pain have, in my own experience, not usually been due to chronic peptic ulcer. Such repeated hemorrhages may be due to gastritis or to recurring acute erosions of the stomach, which heal rapidly whatever their cause, or rarely to hiatal hernia. Unfortunately, however, the true cause of the bleeding may remain undiscovered in many instances of this type.

Gastric malignancy does not cause multiple hemorrhages. If massive bleeding occurs it is generally a single episode, late in the disease, and followed by prolonged oozing of small amounts of blood. However, benign tumors, notably leiomyomas, may bleed repeatedly over a period of months, the growth alternately ulcerating and healing. It is now known also that patients with esophageal varices may have recurrent bouts of bleeding, sometimes at relatively long intervals. Such repeated episodes of bleeding from varices will probably be seen more often in the future as the life span of patients with advanced cirrhosis is lengthened by more satisfactory therapy. Experience in the past indicated that at least 70 per cent of patients with cirrhosis died within a year after the first hemorrhage (Ratnoff and Patek). In general it may be stated, therefore, that a history of previous hemorrhage and recurring digestive distress in a bleeding patient most strongly suggests the presence of ulcer. Even in the absence of digestive pain recurring bleeding is most often due to ulcer, but there are other, though

rarer, possible causes such as gastritis, hiatal hernia, benign tumors, and esophageal varices.

Additional information may be gleaned from other facts in the patient's history. Persistent epigastric discomfort, digestive distress, and weight loss in the months immediately preceding the hemorrhage are characteristic of gastric carcinoma. Substernal distress occurring after going to bed at night and relieved by assuming the upright position suggests hiatal hernia, particularly if the patient is obese and elderly. A history of bouts of cramp-like pain followed by melena is a symptom pattern in some instances of small bowel tumor. Knowledge that the patient has been alcoholic and has had an inadequate diet raises, of course, the strong probability that he is cirrhotic and that the hemorrhage he now has is the result of a ruptured varix. As stated, much may be learned from the history and this first step in diagnosis must never be neglected. Unfortunately, however, many patients are encountered whose histories contribute no information regarding the cause of their bleeding.

Physical Examination

This may also be said of the physical examination of the bleeding patient which, aside from the presence of changes secondary to the hemorrhage itself, may be entirely negative. This is certainly the case in hemorrhage due to ulcer and gastritis and is usually true even when other lesions are responsible. Occasionally, careful physical examination, carried out with due respect for the patient's general condition, may be most revealing. Emaciation, an epigastric mass, enlarged nodes in the neck or axilla, or a palpable rectal shelf are found in some patients with gastric cancer, although failure to find these by no means excludes such a lesion. The finding of purpuric areas or of bleeding from mucous membranes, or the demonstration of splenomegaly or lymph gland enlargement, leads to consideration of one of the blood dyscrasias. Physical examination is most helpful in the search for hepatic cirrhosis, the most common underlying cause of esophageal varices. Bleeding from varices rarely occurs at an early stage of cirrhosis before there is other evidence of the disease. Usually it is a relatively late event and examination will often reveal such other physical signs of cirrhosis as slight jaundice, ascites, splenomegaly, spider angiomas, or even a visible collateral circulation. In examining for ascites and splenomegaly it is advisable, of course, to be extremely gentle in

moving the patient and in practicing percussion and palpation.

Laboratory Procedures

Of laboratory procedures, repeated determinations of the red count, hemoglobin and hematocrit readings, and of the blood urea nitrogen level, are of great value in following the course of the hemorrhage and in gauging its severity. These tests, however, and most of the routine laboratory studies contribute little to the differential diagnosis of hemorrhage. The gastric analysis, usually best deferred until long after the bleeding has stopped, may be of some assistance. The finding of low or absent gastric acid suggests, but only suggests, that a gastric lesion demonstrated by x-ray is malignant rather than benign. Some aid in differentiating benign and malignant stomach lesions is also to be expected from a study of the gastric cytology by the Papanicolaou technique, although this method requires great skill in interpretation and has been shown to be open to certain errors. As with gastric analysis, this type of examination is not to be carried out until there is no longer danger of inciting fresh hemorrhage.

Detailed hematologic studies are of value in recognizing those few instances of gastro-intestinal bleeding due to the blood dyscrasias. These, however, are so rare that examinations of this type are only occasionally helpful in diagnosis. It is in the recognition of hemorrhage from esophageal varices that laboratory procedures are of the greatest assistance. This is because liver disease (cirrhosis) must usually be rather severe before portal hypertension is sufficiently high to cause formation of varices. Although hematemesis occasionally occurs early in the course of cirrhosis, apparently as the result of local "vascular accident" (Ratnoff and Patek), the symptom is usually one that results from advanced disease that has reached a level at which it gives definite laboratory evidence of its presence. It is highly unusual for bleeding from varices to occur without demonstrable liver dysfunction to indicate that definite cirrhotic changes are present.

In the detection of cirrhosis and varices as a cause of hematemesis, the bromsulfalein test has been found to be the simplest and most accurate of the tests in general use. It can be performed with no risk, even immediately after a hemorrhage. I have not found bromsulfalein retention in patients with hemorrhage due to ulcer or

causes other than cirrhosis, but have consistently found retention of the dye in patients who have bled from varices. It has been reported (White and his associates) that slight degrees of bromsulfalein retention may be noted in patients with bleeding ulcer during the stage of shock, the results of the tests rapidly returning to normal as the patients improve. In general it may be stated that failure to demonstrate bromsulfalein retention excludes cirrhosis as a cause of bleeding except for those very rare instances in which hemorrhage occurs quite early in the course of liver disease. The finding of bromsulfalein retention is fairly conclusive evidence of the presence of advanced liver disease and, in the patient who has bled, points to cirrhosis as the cause of the hemorrhage. If, however, dye retention is demonstrated while the patient is in shock, it is best to repeat the test on recovery from this in order to be certain that temporary circulatory changes have not caused the positive findings.

X-ray Examinations

It is unfortunate that the information derived from the patient's history, physical examination, and laboratory studies frequently does not permit reaching a definite decision regarding the cause of a hemorrhage. For this reason x-ray examination of the upper gastro-intestinal tract has come to be the critical procedure and the one most relied upon to find a lesion or exclude its presence. The question, therefore, is not whether x-ray studies should be carried out following a hemorrhage but when these should be done. In the past it was generally the custom to postpone roentgen examination until two or three weeks after a massive hemorrhage because of the opinion that earlier studies carried the risk of causing further bleeding. It was observed, however, that examination so long after bleeding often failed to reveal a lesion and it was believed that during the waiting period an ulcer that might have been discovered earlier had had time to heal. For this reason x-ray examination soon after a hemorrhage was advocated. Schatzki, for example, advised x-ray studies shortly after bleeding had stopped, or even during bleeding, but not while the patient was in shock. Further impetus to the idea of earlier x-ray examinations was given by the rather widespread use of the policy of prompt feeding of bleeding patients. It was believed that a stomach able to tolerate food could also tolerate barium. The plan of subjecting patients to x-ray investigation early after a

hemorrhage has gradually gained acceptance and is now used by a number of clinicians (Schiff, Jones, and White). The patient is transported to the x-ray department with a minimum of exertion on his part. He is examined in the horizontal position and without palpation and pressure. Peristalsis and gravity (as the patient is turned) are relied upon to distribute the barium (Hampton). Frequent spot films are taken. It is admitted that this method may not permit examination of the entire stomach, but it is claimed that many ulcers, as well as gastric tumors, hiatal hernias, and esophageal varices, will be discovered in this way.

There is much to be said in favor of having x-rays taken soon after the subsidence of a hemorrhage. Everyone who has experienced the sense of frustration that comes with "negative" findings—findings that fail to explain an episode as striking as massive bleeding—has the desire to carry out intensive studies at a time when these seem more likely to give positive information. It must be recognized, however, that subjecting the patient to x-ray studies in the earliest post-hemorrhagic period is a diagnostic procedure that has some limitations.

There is, first of all, the question of the risk involved. The transportation and manipulation incident to the x-ray studies do carry some danger of renewing the bleeding. These are increased if the patient is examined by a hurried roentgenologist working in a crowded department. Though minimized if the study is done in a most gentle manner, with careful turning of the patient and avoidance of pressure, some risk is entailed and is undoubtedly greatest for those patients for whom the examination is most needed—the elderly and those with severe bleeding. The need for avoiding compression and undue palpation restricts the accuracy of the procedure. It is sometimes difficult enough for the roentgenologist to demonstrate a lesion even if he can carry out his examination with free use of compression and active manipulation of the patient. With the gentle examination that must be done immediately after a hemorrhage there is increased likelihood of missing a small ulcer of the stomach or cap, or a lesion high in the body of the stomach or on its posterior wall. Since one of the chief reasons for the early study is the hope of discovering an ulcer so small that it might heal in the usual waiting period, the lesion we are often most eager to demonstrate is the one most likely to be missed.

A negative x-ray immediately after a hemorrhage does not exclude the presence of ulcer as the cause of the bleeding. It has been stated that later x-rays, taken after edema and the clot have disappeared and a scar has formed, may reveal ulcers missed by earlier studies, and for that reason it has been suggested that taking films soon after a hemorrhage may not increase the number of ulcers diagnosed (Crohn et al.). There is also a possibility of positive errors if x-rays are taken at a time when blood clots are in the stomach since these may mimic the filling defect of a new growth. Briefly, then, the practice of x-raying patients immediately after a hemorrhage introduces some inaccuracies which must be recognized by those who follow it.

It seems best not to have a fixed time for the x-ray studies of patients who have bled. In the majority of instances, studies at 10 to 14 days after the hemorrhage will give as much diagnostic information as can be obtained from earlier studies and no risk is involved. Immediate x-rays are not necessary for those patients definitely known to have had ulcers in the past. They do not seem advisable if the clinical features or bromsulphalein test suggest the presence of esophageal varices. Early x-ray studies are most helpful in investigating those patients who have had previous hemorrhages of undiscovered origin. They are also valuable in studying older patients who have recently bled and those whose clinical course indicates that an operation may become necessary. In these the absence of a demonstrable lesion may prevent performance of an injudicious operation or localization of the lesion may be of distinct help to the surgeon and the moderate additional risk of early x-ray is justified. If early x-rays are planned, the studies should be done, if possible, 24 to 48 hours after massive bleeding has stopped and certainly not while the patient is in shock. The roentgenologist must understand the need for extreme care in handling the patient and his full cooperation obtained. If early x-rays fail to reveal a lesion, the examination should be repeated one or two weeks later when more detailed studies can be carried out.

In those instances in which nothing is found in the esophagus, stomach, or duodenum, thought must be given to a small bowel lesion as a cause of melena. Small bowel disease is only a rare source of massive hemorrhage, but for this reason it is frequently overlooked. The problem of its recognition was most recently reviewed by

Hodes, who found melena to have been a prominent symptom in 31 patients among 161 with small bowel lesions studied over an eight-year period. The lesions which bled included diverticula, tuberculous and non-tuberculous enteritis, and benign and malignant tumors of various types. As in the case of benign tumors of the stomach, hemorrhage may be the major symptom of benign tumors of the small intestine and may, in fact, cause the death of patients who have never had previous symptoms, such as pain or obstruction. Knowledge of the importance of these lesions makes it imperative to search for them, and certainly in those cases for which no other explanation for melena can be found. X-ray studies of the small bowel should be done by means of detailed progress films. If no definite defect is discovered but suspicion of the existence of one still remains, the small bowel should be studied further by intubation (Lorber).

Gastrosocopy

Esophagosocopic examination is usually neither advisable nor necessary for the diagnosis of varices early in the post-hemorrhagic period. The presence of these is usually sufficiently suggested by clinical findings and the results of the bromsulfalein test, and more easily and safely confirmed by subsequent x-ray than by direct visualization. If the diagnosis of varices remains in doubt, esophagosocopy can be done following recovery from the acute manifestations of hemorrhage. Gastrosocopy, on the other hand, may be of great diagnostic value if performed relatively soon after a hemorrhage. As with x-ray studies, the time at which this is done will influence the significance of the findings. In patients who have had a recent hemorrhage, the chief value of gastrosocopy lies in the aid it gives in determining the presence of gastritis to account for the bleeding.

Although it is widely believed that gastritis is second only to ulcer among the intragastric lesions causing bleeding, this point remains to be established. The importance given to gastritis as a cause of hemorrhage arises from the fact that x-ray examinations of the stomach and duodenum two or three weeks after a hemorrhage so frequently fail to reveal any defect. How often, in such cases, bleeding has been due to an ulcer that has healed and how often to gastritis that the x-ray is unable to demonstrate is unknown, but gastritis is often considered to be present. De la Vesca has been quoted as attributing more

than 10 per cent of gross hemorrhage to gastritis. It was reported as the source of bleeding in 1.5 per cent of Schiff's patients, in 3.6 per cent of Thompson's, and in 6.3 per cent of those of White and Chalmers. Benedict, however, reported bleeding in almost 20 per cent of patients with gastritis. Schindler observed gross bleeding in all types of gastritis and stated that it may occur in the absence of other symptoms. I have seen bleeding areas in the stomach of 6 patients with gastric atrophy.

The role of gastritis—a term still used quite loosely—in the production of gastric symptoms of all types is still undetermined. The exact relation of gastritis to gross hemorrhage will not be settled until many more patients have been subjected to gastrosocopic examination shortly after hemorrhages. I do not, however, recommend that all patients who have bled be examined with the gastroscope. The instrument should not be passed until esophageal varices or lesions causing possible esophageal obstruction have been excluded by x-ray and appropriate laboratory studies. Gastrosocopy is ordinarily not needed if x-rays have revealed an ulcer or another lesion which seems to explain the hemorrhage. This examination should be carried out if no definite lesion is found by x-ray and is particularly advisable in studying those patients who have had previous hemorrhages for which no source has been found. It is in these patients particularly that changes in the gastric mucosa may be found to account for bleeding.

If gastrosocopy is done in searching for the cause of bleeding, it should be performed within a few days after gross hemorrhage has ceased, but only after the x-ray examinations have been carried out. Gastric mucosal changes capable of causing bleeding—whether inflammatory, allergic, or vasomotor in origin—may be of short duration and may disappear if many days elapse between hemorrhage and examination. The same may be true of the "acute" ulcers. I have used the gastroscope in a few patients within five to seven days after hemorrhage without ill effects. However, I believe that there is some danger in overinflating the stomach at this time and I would advise that the examination be carried out with great caution if done soon after bleeding, and preferably only in those patients in whom the occurrence of repeated unexplained hemorrhages makes it imperative to use all diagnostic methods at that time.

Gastrosocopy may also be helpful in determin-

ing whether a hiatal hernia is the cause of bleeding. A hiatal hernia was found in 21 of the 400 cases (5 per cent) of gross hematemesis of White and Chalmers. Sahler and Hampton reported 221 patients with hiatal hernia; 32 of these had either marked anemia or gave a history of gross bleeding. Bleeding from the herniated portion of the stomach is probably the result of both venous congestion and ulceration of the gastric mucosa. There may be slow oozing of blood leading to anemia or, on occasion, gross hemorrhage. The latter is relatively rare in proportion to the number of patients found to have hiatal hernia and demonstration of such a hernia by x-ray does not prove that this was the cause of hemorrhage. By gastroscopy it is usually possible to visualize satisfactorily the mucosa of the herniated portion of the stomach. The procedure, carried out shortly after a hemorrhage, has occasionally enabled me to see bleeding points in this area and to satisfy myself that the hernia was, in fact, the cause of hemorrhage.

"Bleeding of Unknown Origin"

Unfortunately, detailed studies of patients with massive hemorrhage will not always lead to a satisfactory explanation of the bleeding. A group will remain with "bleeding of unknown origin" as a diagnosis. This was the case in 9 per cent of the patients reviewed by Jankelson and 9.5 per cent of those of White and Chalmers. Crohn and his associates could find no adequate explanation for hemorrhage in 22 of 102 patients who bled. A patient may have only one hemorrhage of undetermined origin, but patients are also seen who bleed repeatedly over periods of years without the cause being found.

It is customary in these cases to ascribe the bleeding to ulcers that heal rapidly or to recurring episodes of gastritis, but these theories seem to be incompletely supported. It is true that the stomachs resected during hemorrhage have been reported as revealing shallow ulcers with "open vessels" (Stewart et al.). Attention must be called, on the other hand, to those patients who have subtotal gastrectomies without any lesion being found in the stomach or duodenum and also to those few who, after repeated hemorrhages, have ultimately been examined at autopsy without any cause for bleeding being demonstrated (Jankelson). Although it cannot be denied that these individuals may have acute ulcers that heal rapidly, or erosions or other changes secondary to gastritis, the fact that many

of them never have significant digestive symptoms makes it seem unlikely that they have well-defined gastric disease. It may be that other acute disturbances of the gastric mucosa—of allergic or vasomotor origin—may occur, although little is known of these. Hemorrhages of this indeterminate type may, furthermore, cause some of the bleeding which occurs in patients with more obvious lesions, such as ulcer or hiatal hernia.

These mysterious hemorrhages present tremendous diagnostic difficulties. When they occur only once, a diagnosis of a rapidly healing ulcer or of transient gastritis may be acceptable. This is not the case when bleeding recurs repeatedly. Under these circumstances a detailed diagnostic program should be followed. Not only should the patient's history be reviewed in detail for symptoms of digestive disease but the family history should also be investigated for other instances of bleeding. Questions should be asked concerning allergies to food and sensitivities to drugs, such as aspirin (Douthwaite and Lintott). The physical examination of the patient and his family should include a search for telangiectatic areas. Complete hematologic examinations should be carried out. In attempting to find the bleeding area in the gastro-intestinal tract, the string test of Einhorn may be most helpful if done before bleeding stops entirely. This simple procedure will often localize the hemorrhagic lesion and enable the roentgenologist to focus greater attention on the region most strongly suspected. Of course, these patients should have detailed and repeated x-ray studies of the entire gastro-intestinal system. They should include search not only for ulcer but also for hiatal hernia, esophageal lesions, small tumors of the stomach and, if melena has been the only form of bleeding, small bowel lesions. These last are often most difficult to find and defects such as a Meckel's diverticulum may never be satisfactorily visualized. Because of the need for every diagnostic assistance, there is justification for early x-ray studies of these patients and these should be done, with care, within 24 to 48 hours after gross bleeding has stopped. The same is true of the gastroscopic examination and this should also be performed early so that any hemorrhagic mucosal changes can be found before they disappear.

It is obvious that the investigation of a patient with repeated hemorrhages and no easily found lesion is difficult and time-consuming. It must be persisted in, however, and occasionally, after a

long period of observation, the cause of the bleeding is found in a small ulcer, gastric mucosal disease, a hiatal hernia, or a small bowel tumor or other abnormality. It is the eventual diagnosis of lesions of this type that inspires continued study of patients with repeated hemorrhages, even though in many instances the search is unrewarded.

Summary

Massive hemorrhage from the gastro-intestinal tract is often difficult to trace to its source because of the absence of associated symptoms and the difficulty of carrying out diagnostic studies shortly after the hemorrhage.

The majority of hemorrhages are the result of peptic ulcer, gastritis, or esophageal varices. The predominance of these in statistical studies of hemorrhage must not, however, result in failure to search for less frequent causes. Ulcer and gastritis are often accepted as causes for hemorrhage without critical studies and without definite demonstration of the presence of these lesions. Bleeding may be due to a number of rarer diseases, or no definite lesion may be discovered.

The patient's history and physical examination may be of little assistance in arriving at a diagnosis of the cause of bleeding, but must never be neglected. The history is of greatest value in the recognition of ulcer, but approximately 25 per cent of those who bleed from an ulcer have had no previous digestive symptoms. In these the diagnosis of ulcer may be established by x-ray demonstration of an ulcer and/or the development of digestive pain at some time after the hemorrhage.

Laboratory studies also usually offer little help in recognizing the causes of most hemorrhages. The bromsulfalein test, however, is almost always positive when bleeding is due to esophageal varices, and the absence of bromsulfalein retention can usually be considered to exclude varices as the source of hemorrhage.

In most instances detailed x-ray study of the upper gastro-intestinal tract is the critical procedure in diagnosing the cause of hemorrhage. In the hope of discovering lesions which may heal rapidly, the practice of taking x-rays shortly after bleeding is being advocated. This seems of particular value in patients who have had previous hemorrhages of unrecognized origin, in elderly patients, and in those whose course suggests that surgery may be necessary, but in many patients early studies offer no advantage. If

studies are done early in the post-hemorrhagic period, extreme care is needed to lessen the risk. If no lesion is found with these studies, roentgen examination should be repeated when a more thorough examination can be made.

Gastroscopy is of great value in recognizing gastric mucosal disease and, occasionally, hiatal hernia as sources of bleeding. To be of greatest service, this examination should be done early in the post-hemorrhagic course. Because of possible risk involved, gastroscopic examination of those who have bled recently should be done only if no other lesion has been found by x-ray and is best reserved for the investigation of patients who have had repeated hemorrhages.

Despite careful study, no satisfactory explanation may be found for bleeding, even when this recurs repeatedly. These "silent" hemorrhages are often ascribed to an ulcer even in the absence of other symptoms and although no ulcer is found by x-ray. They may be due to acute ulcers that heal rapidly or to transient gastric mucosal changes, but it is often impossible to prove the presence of these. Investigation of hemorrhages of this type calls for detailed and repeated studies of the entire upper gastro-intestinal tract in a search for ulcer, benign gastric tumors, gastric mucosal diseases, hiatal hernia, and small bowel lesions. In some cases even the most careful and persistent study will fail to reveal a lesion that can be considered the source of hemorrhage.

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HOLIDAY—VACATION—HARDSHIP

The return of warm weather brings forth the desire of a vacation, which is expensive and only a small percentage of self-employed can really afford to take a refreshing trip.

Capital and labor have come to some agreement whereby the employees have a paid vacation. Management by charging all expenses to the governing of the business can very well relax in the sunlight—and return as rejuvenated men of vigor.

How many medical men can really take a vacation? Can a medical man make a deduction against his depreciation for a future year? What security is there for an old doctor who is unable to follow his work? Will he be able to collect unemployment insurance? No—he will only collect while he is able to earn and taxation leaves enough for a meager living. Medical men do not ask for, nor give any quarter; they are law-abiding men and want to remain so. There are certain qualities which distinguish and characterize the members of the medical profession. Even though they may seem somewhat nebulous and intangible, they are actual and real. They are determining factors in the character and extent of the physician's practice. They are described and designated by three words—ability, amiability, and dependability. Ability is almost entirely acquired, by long hours of concentrated study. Amiability—personal trait—can and must be cultivated. It manifests itself in the spirit of cooperation. Its reward to the physician is a feeling of work well done. Dependability is the essential ingredient in the art of medicine. It is conditioned by the physician's attitude toward his work which, when discharged with loyalty and cheerfulness, the compensation in personal satisfaction overshadows the financial reward. Medical men must be free from financial want and academic fear. Freedom implies, however, something more than non-interference by authority—whether political or economic. It implies a vigorous encouragement and support, a friendly social environment.—*The Medical Society Reporter*, Scranton, Pa., June, 1950.

DROP THE REDS!

For some months the medical profession has been concerned with the activities of an organization known as AIMS, an abbreviation for the Association of Interns and Medical Students.

AIMS, a national organization, has a chapter in three of the five medical schools in this city.

According to literature distributed on the campuses, its object is the "advancement" of students. On the face of it this sounds like a healthy motive. Even the most conservative could find no fault with a group which would help medical students to become good doctors and thus fit them to minister to the ills of humanity.

But AIMS is directly affiliated with the International Union of Students whose headquarters is in Prague, Czechoslovakia. AIMS makes no attempt to hide the fact; indeed it has, from time to time, actively engaged in collecting funds to send to the International Union of Students which is high on the FBI's list of Communist organizations. Our concern is that American students living in the United States, enjoying the protection and the freedom of this government, and taking full advantage of the finest educational system in the world, should ally themselves with an outfit that means to destroy all we stand for.

It is a poor business to accept the privileges of American citizenship and at the same time engage in vigorous and active support of Communism.

Yes, it's a free country, the last free country on earth, where the individual can speak and act as he pleases. But there is a great difference between freedom and license. There is free speech in this country—a little *too* free when young men and women, with their vague, loose talk of "international brotherhood," can abuse the United States and aid in the attempt of Communists to ruin the country.

We suggest that AIMS sever its connection with the Reds, the pinks, and the fellow-travelers, and confine its activities to the principles of American medicine which has no place for Communism.—*Philadelphia Medicine*.

INNOVATION FOR 1950 PROGRAM

Paul C. Craig, M.D., of Reading, is already enthusiastic about the prospects for the Thursday afternoon Study Club series designed to climax the State Society's 1950 scientific program. Those of us who know the genius and dogged energy which he displays in such situations are satisfied that the varied and readily absorbed sources of instruction which he will arrange will well repay those of our membership who will remain throughout Thursday afternoon of the 1950 convention week in Philadelphia—October 15-19 (see August JOURNAL for detailed program).

The Surgical Management of Massive Hemorrhage in Peptic Ulcer

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OUR IDEAS concerning the management of massive hemorrhage from peptic ulcer have undergone considerable change in the past few years. At one time, within the memory of most of us, the problem was generally considered to be one for the medical man only. Patients suffering from this condition were treated by rest, morphine, starvation, and hope. It was considered unsafe to administer either blood or other fluids by vein because it was believed that the increase in blood pressure would encourage continuation of the bleeding and discourage spontaneous arrest. The hemorrhage was considered to be more or less self-limited by the hypotension. This was true in the same sense that it is true that cadavers do not bleed and that if the patient died at least he died cured of active hemorrhage. Furthermore, the idea was generally held that practically none did die from this type of hemorrhage. A more critical examination of the records, instituted largely by surgeons, brought to light the fact that the actual mortality from massive hemorrhage in peptic ulcer was from 20 to 25 per cent. Our approach to the management of a condition which is fatal to one in every four or five must be quite different from that to one from which practically all recover.

Examination of the statistics covering the combined experience of a number of observers will reveal that a large proportion of patients treated conservatively will recover. These figures are misleading and lead inevitably to wrong conclusions if a properly critical analysis is not made. It is not to the 75 to 80 per cent who recover that we must direct our attention, but to the 25 per cent who die. When one considers that these deaths are due to hemorrhage and that hemorrhage is a condition amenable to specific

measures, i.e., transfusion and arrest of bleeding at the source, this 20 to 25 per cent mortality is at once a reproach and a challenge to the profession.

When surgeons first began to operate upon these patients, the only cases coming to operation were those which had been treated conservatively for several days, many of them in extremis, or at least in a condition which precluded survival of any sort of operative procedure. The results were inevitably unsatisfactory. The generally unsatisfactory results from surgery further encouraged those who advocated the policy of masterful inactivity. Gradually, a better understanding of the problem has been brought about which has resulted in agreement between surgeons and medical men regarding the indications for operation, and the mortality is steadily declining.

The most important factor in this whole problem is to recognize the patient in whom spontaneous arrest is not going to occur, and to operate upon him (her) before rapid and continuing blood loss has rendered the condition irreversible. At the outset most of these patients present a typical picture, namely, pallor, low blood pressure, rapid pulse, air hunger, and apprehension. The blood picture is that of profound anemia, often out of all proportion to the measurable blood loss since usually, after the first episode of hematemesis, the blood passes into the intestine to be manifested later as the characteristic tarry stool. The usual treatment at this point is to transfuse rather slowly, administer morphine to relieve apprehension, give oxygen if it seems to afford symptomatic relief, and by hourly blood counts, frequent blood pressure determinations, etc., to observe the direction in which events are moving.

In the most favorable cases, improvement will be progressive; there will be no more vomiting,

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the blood pressure will increase, and the hemoglobin will remain stationary or begin to rise. These are indications that cessation of bleeding is taking place. In another group, no improvement may be noted until a second or third transfusion has been given, usually after about twelve hours. This group requires constant and skillful observation because no one can tell just what is going to happen. Any sign of worsening of the situation is an indication for operative intervention. In a third group the situation is bad from the outset. In spite of repeated or continuous transfusion of blood in the ordinary amounts (500 to 1000 cc.), the blood pressure remains low, the hemoglobin continues to fall, vomiting of blood is repeated, or bright red blood is passed by bowel. These are the patients who die if not operated upon or if operation is postponed too long. Sometimes the intermediate type will slide into this last group in a very short time. Failure to recognize these cases is largely responsible for the mortality in massive hemorrhage from peptic ulcer. A point to be emphasized is that we must rely on objective signs in arriving at a decision to operate and not on such factors as age, probable condition of the arteries, history of previous hemorrhage, etc. These points make interesting reading and discussion, but bear in mind that young men with soft vessels and no history of either indigestion or previous hemorrhage have been known to die unoperated upon because they did not conform to a pattern.

Having decided that operation is indicated, the rate of transfusion should be stepped up and as much blood as possible gotten into the patient in the shortest time compatible with safety. Sufficient blood should be at hand to provide for continuous administration during the operation and for some time afterward.

It is neither necessary nor desirable to undertake any detailed discussion of the actual surgical procedures at this point, but a few points of general interest are in order. Originally surgery was confined to direct attacks upon the bleeding vessel by ligation, cauterization, oversewing, etc. Such procedures might be combined with gastroenterostomy or pyloroplasty. Attempts to control bleeding by ligation of the possible arterial

blood supply to the area were tried with indifferent but occasionally good results. When at long last we began to appreciate the necessity for the transfusion of large amounts of blood, not only after but before and during operations of a formidable nature, surgeons assumed a bolder attitude in operating upon these patients. Subtotal gastrectomy is now considered to be the operation of choice and probably the only operation having much to offer in the really bad case. This is a formidable procedure in an emergency, but it becomes less so when one considers that the risk is a bad one for one reason, namely, that the patient is in critical condition from loss of blood, and that for loss of blood we have a specific remedy — replacement. With good anesthesia and good technique, the very poor risk thus is converted into a reasonably good one.

The opinions expressed in this paper are based largely on a personal experience with 92 cases treated in the past ten years. Of these, only 26 were operated upon. Of the 26 patients operated upon, 21 recovered and 5 died. Of the 66 patients treated without operation, 62 recovered and 4 died. Thus it would appear that conservative management gave better results than did operation. As stated previously, this is not the point which we wish to stress. An analysis of the deaths in each group will show, I think, that of the 9 patients who died 4 might have been saved if surgery had been undertaken earlier. It is of special interest to note that of the patients concerned in this study 68 had a long-standing history of ulcer, while only 8 had previous hemorrhage.

In conclusion, we wish to restate our position, which may be summarized as follows:

1. Massive hemorrhage from peptic ulcer carries a high mortality.
2. A majority of the patients in our series recovered under conservative management.
3. If marked improvement indicative of arrest of bleeding does not occur promptly, surgery should be undertaken at the earliest possible moment.
4. Massive transfusion of blood is the *sine qua non* of the preoperative, operative, and post-operative periods.

The Problem of the Compound Fracture

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IN ST. LOUIS in 1932 I reviewed the results of treatment of 304 compound fractures of the long bones by early débridement, Carrel-Dakin technique, and internal fixation with steel plates when necessary. Since then various factors have come to our aid—the sulfa drugs, the antibiotics, and better steel in our plates and screws, but in reviewing our results for the past 15 years in the treatment of compound fractures, they were only moderately improved over the previous 15 years. The findings in this latter survey were disappointing—osteomyelitis and non-union still occurred all too frequently. Since the advent of the sulfa drugs, then later the antibiotics, an attempt was made to treat these compound fractures of the long bones by early débridement, internal fixation when necessary, and closure when possible. In reviewing all of these factors which have gone into the treatment of compound fractures over these years, I think we are able to form an opinion as to the value of the various components in compound fracture treatment.

Early thorough débridement is to my mind the most important single factor in the treatment of these injuries. The ability to recognize and remove dead and dying soft tissue, the removal of completely separated bone fragments which if deprived of their blood supply are certain to sequestrate, the meticulous removal of all foreign matter, the opening and exploring of every recess in the compound fracture—these are the procedures which combat most successfully the worst complication of compound fractures, namely, infection.

Early closure of the compound wound—to convert these fractures into simple fractures—is the ultimate in treatment. In the small puncture wound this is easily done, but it should be done not only early but under general or spinal anesthesia so that a proper débridement can be car-

ried out and the small puncture wound which may lead into a large subcutaneous space may be thoroughly explored and cleansed and a satisfactory permanent closure made. Under no circumstances, however, should these compound wounds be closed under tension; this shuts off the blood supply and causes devitalization of tissue leading on to infection. Thiersch or split thickness skin grafts should be used liberally to close these compound wounds.

Third in importance is penicillin. To me this drug has been disappointing in the treatment of compound fractures, and anyone who has been careless in his technique in the hope that penicillin would make up for his laxity certainly found that infections arise in wounds containing crushed and dead soft tissue, bone fragments, or foreign material just as readily with penicillin as without. It should be used in large doses—100,000 units every three hours—for the first three days and followed up by 400,000 units every 18 hours for a week.

The use of stainless steel plates as a means of internal fixation is frequently necessary, but they are definitely hazardous, probably due to the new areas of bone opened up by the insertion of the screws and the partial removal of the periosteal covering of the bone to insert the screws. They are sometimes necessary, but if a reduction can be carried out by manipulation and external fixation it is much better, as plates are definitely detrimental in compound fractures.

At the present time we are treating our compound fractures of the long bones as follows:

1. Early thorough débridement of the compound wound. This should be carried out within the first eight hours, and if the patient is in shock, anti-shock therapy may be given at the time the wound is being treated. It is bad judgment to attempt a closure of a compound fracture that has gone untreated for 24 hours.

2. Closure of the compound wound without

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tension. Thiersch grafts are used liberally to close areas which cannot be sutured firmly and without tension. The injured limb is elevated on returning the patient to his bed and paravertebral novocain injections are given daily during the early postoperative period in order to eliminate the edema.

3. Fixation.

- A. If the fragments can be placed in good position, they are held by lateral plaster splints.
- B. If badly comminuted with overriding, skeletal traction with Kirschner wire is carried out under strict asepsis, being ever mindful of the high percentage of infections associated with skeletal traction.
- C. If the fragments cannot be definitely held without the use of a plate, then the swelling in the limb is allowed to subside, the skin grafts healed, and suture line closed and healed. Then one to four weeks later this fracture which has now been turned into a simple fracture is

opened and the fragments approximated, a suitable plate applied, and the soft tissues closed. Lateral plaster splints are applied. This is a radical departure in the treatment of these badly macerated limbs, but in principle and practice is very satisfactory.

The emphasis on treatment of the soft parts involved in a seriously mutilated limb is definitely a step in the right direction. The delay in reduction of the bone fragments for two or three, or even four, weeks until healthy soft tissue has been obtained has not appeared to be detrimental to union. Everything possible should be done to prevent infection, and this includes the elimination of entirely separated bone fragments even if this causes a gap in bone continuity. Just recently a sliding bone graft was carried out five weeks after a compound fracture was sustained, and the graft replaced a large "V" in the anterior portion of the tibia which had been evulsed at the time of the original injury. In this way time was saved in eliminating the chance of infection and the man is going on to a satisfactory bony union.

"THE LAITY"

Our dictionary defines the word "laity" as the people as distinguished from the clergy—those outside any profession.

For generations it has been the custom for the medical profession in scientific publications or platform appearances to designate all extra-medical persons as "the laity." Similarly, the clergy refer to all outside the ministerial group as laymen. In the legal profession there is, in a more restricted sense, similar usage of the word to denote those who have not achieved lawyer status. For all we know the underworld may have—before coining the word "suckers" for their use—used the same term to designate all those who were not of their fraternity.

In the interests of better public relations for the medical profession, it seems to us that we would do well to abandon the term for something which can in no sense be mistaken as carrying or intending a contemptuous or belittling connotation. While the usage of the word "laity" is perfectly correct grammatically, we wonder whether it does not belong in another era when the medical profession had to build up its ego and self-assurance to compensate for its scientific shortcomings. To the extent that the word in its usage implies a "you wouldn't understand" or "I know more than you do" feeling, it is poor practice.

Someone once wrote a book entitled "Patients Are People." Medicine has done much to inform the public

on medical subjects. No group or profession has a monopoly on knowledge. Even in medicine there are allied workers and professions who have an extensive knowledge of certain phases of medicine.

We as a profession dislike to be looked down upon. The public doubtless feels the same way toward us. Let us refer to them in a group sense as our patients or as the public. It won't cost much and it might be a strong rail in mending our public relations fences.—*Westchester (N. Y.) Medical Bulletin.*

HEALING, ALSO, TOO EXPENSIVE?

The *London Daily Mail* furnishes a quote from a doctor which brings home all too clearly the inherent dangers in a socialist control-minded health system. It speaks for itself:

"Lord Horder, one of the King's doctors, accused the labor government today of putting undue controls on the medical profession. Great Britain's socialized medicine program, he said, recently posted a notice in one hospital reading, 'Operating theater will not be used except between the hours of 9:00 a.m. and 5:30 p.m.' Another example of government control, he said, was an order to hospitals saying, 'Use of penicillin in this hospital must be cut down. It is too expensive.'"—*Minneapolis Medicine*, May, 1950.

THORACIC INJURIES

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and JOHN H. HALL, M.D.

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THE HANDLING of thoracic injuries assumed a role of great importance during the recent war, and the fact that a great deal was learned about them is demonstrated by the reduction in mortality of chest wounds from 24.05 per cent in World War I to 8.1 per cent in World War II. It is to the eternal credit of the medical armed services that accurate records of improved methods have been preserved.

In civilian practice, the problem of handling thoracic injuries is encountered only occasionally, but when an emergency arises, intelligent treatment is so important that the knowledge of certain basic principles is necessary.

In severe crushing injuries of the thorax, the prognosis depends on the extent of injury to the vital structures contained in the thorax, and also, of course, injury to associated important structures elsewhere. Many of the patients are dead or dying when first seen and every patient with a crushing injury of the thorax should be considered in serious condition and as being in shock until proved otherwise. Therefore, in general, it is well to avoid doing anything which will increase the shock. Open operation as an emergency measure is contraindicated for thoracic injuries unless the necessity for such operation is proved. The main stays of supportive therapy are (1) oxygen and (2) blood transfusion. These should be utilized as the patient's condition is being reviewed.

Thoracic injuries are divided into open and closed types. In closed trauma, if injury has occurred to mediastinal structures, especially the heart, the patient usually dies very quickly. If injury is of a perforating type, several things may have occurred. The hole may be large enough to allow air to be sucked in from the outside. This sucking wound of the thorax should

be plugged immediately by any available measure to avoid mediastinal instability and flutter. If sterile material is not at hand, any temporary measure, even the use of a finger, should be utilized. A living patient can easily be cured of an incidental empyema. If the lung has been torn by a sharp instrument entering the chest, or by protrusion of a broken rib, tension pneumothorax may develop. If more than one needle aspiration is required to eliminate this pneumothorax and quickly expand the lung, intubation with a No. 30 French intercostal tube should be employed and constant suction applied. If this does not quickly and progressively expand the lung and the patient does not improve, one must resort to open thoracotomy.

Hemothorax from either open or closed trauma requires immediate aspiration. This should be complete and may be repeated as indicated. Blood lost in such fashion should be quickly replaced. If the bleeding continues and is apparently progressive, open thoracotomy should be done to repair the rent in the intercostal vessel, the large pulmonary vessel, or the chamber of the heart which might be producing the hemothorax. Every measure which points toward re-expansion and utilization of all available lung structure should be used. The quicker expansion takes place and utilization of lung occurs, the more rapid is the return of the injured person to normal.

In addition to these general and local measures, it may be necessary to aspirate excessive bronchial secretions which often accumulate after trauma. This may be accomplished in several ways. Injection of intercostal nerves supplying injured areas will often result in freer respirations and thus encourage spontaneous coughing, which will eliminate retained secretions. Aspiration of the hypopharynx and even of the trachea with a rubber catheter may be utilized. Bronchoscopic aspiration is most helpful if it is available.

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From Temple University Hospital, Philadelphia.

If a foreign body is retained inside the thorax, it should receive secondary consideration. If easily available during débridement, it should of course be removed at the time of primary repair, but, as a rule, a retained foreign body over 1 cm. in size or one lying near an important structure such as the heart or aorta should be removed after the immediate effects of the trauma have completely subsided and the patient has returned to normal. Probing for a foreign body during the period of immediate post-traumatic shock is to be condemned.

A thoraco-abdominal injury should be considered separately. The abdominal portion of a penetrating injury must be handled as a surgical emergency in contrast to the preferred watchful waiting of the uncomplicated thoracic injury.

Subcutaneous emphysema associated with chest trauma is rarely of much significance, although the appearance is terrifying to the uninitiated. Although it has been reported, I have not seen a case which required puncture of a subcutaneous emphysema.

Although it is sometimes necessary to apply skeletal traction for the support of a crushed thorax, this situation is also unusual. If instability is marked, "towel clip" traction or something similar applied under local anesthesia may bring some relief.

The possibility of injury to the esophagus or the trachea must be remembered, especially with a penetrating injury.

In conclusion, emphasis should be placed on doing as little as possible as quickly as possible to restore pulmonary physiology.

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WILL MEDICINE NEED A NEW LANGUAGE?

Doctors and research scientists labor unceasingly to discover more facts about more things in order to reduce guesswork in the applied art and science of medicine. Is it time to consider how information of progress shall be conveyed about results?

Non-medical people have an abiding and encouraging interest, a healthy curiosity to know what goes on. To a certain extent, the "science writers" have an appropriate function in this field and their work in the daily press seems on the whole excellent. With the growth, for example, of the number of synthetic chemical substances coming into use, their complicated formulae have necessitated the creation of synthetic nomenclature. But this is only one aspect of the problem. Doctors in conversing with non-medical patients are often at a loss to know how to describe in understandable language what is the matter with them and what the doctor proposes to do about it.

Medical language reflects its long history. Necessarily it has had to be compounded of Latin and Greek terms to which have been added in the course of time accretions from other sources. More recently have come

the trade names of many articles, biologicals, synthetic products, and a rather loose use of the English language which does not always convey to a listener what the speaker intends to transmit.

The net result is that the doctors may be and frequently are charged with the use of "medical jargon." Many non-medical people think that this is intentional which, of course, in most instances is far from the fact. Nevertheless, it is foreseen that somehow a simplification of expression will have to be worked out, probably based on the plane of the "comics" or the language content of the "movies" and, more recently, the video programs.

If some solution of the problem is not arrived at, the day may soon come when, on the basis of its alleged jargon or jabberwocky, the medical profession may be adjudged to be "high hat" and come eventually to be classed with the professional politicians whose "gobbledygook" has set them latterly in the seats of the mighty, sematologically speaking. This would be unfortunate because doctors, by and large, are plain working people and should have available a plain working language in which to speak to the folks.—*Westchester (N. Y.) Medical Bulletin*, June, 1950.

CARCINOMA OF THE ESOPHAGUS

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Philadelphia, Pa.

UNTIL recently, patients with carcinoma of the esophagus were treated with palliative measures, or the thoracic esophagus was resected without restoration of continuity after the method of Torek.

Carcinoma of the esophagus represents 5 per cent of all carcinoma found in the body.¹ It is a disease predominantly of the male sex, and fully 80 per cent of the cases are patients over 40 years of age.² Feldman³ found that 47 per cent were located in the lower third, 36 per cent in the middle third, and 17 per cent in the upper third of the esophagus. There are two histologic types of the lesion—the more common squamous epithelioma which may occur at any level, and the rarer adenocarcinoma at the lower end where the mucosa may be gastric in type. Carcinoma of the cardiac end of the stomach often invades the lower end of the esophagus.⁴ Grossly, the esophageal carcinoma may be projecting polypoid, ulcerating, or scirrhus encircling. The scirrhus encircling type may spread in the submucosa and muscular coats a distance of one inch without gross mucosal evidence of the disease.⁵

The results following resection of malignancies of the esophagus with intrathoracic esophagogastric anastomosis are encouraging enough to strive for early diagnosis. With the available well-trained roentgenologists within reach of all communities, the immediate employment of this diagnostic aid is imperative. If the x-ray signs are suspicious but not conclusive the esophagoscope will aid in the final diagnosis. In some cases of scirrhus carcinoma the roentgenographic defect may be one of annular constriction which cannot be differentiated from benign stenosis. In that event esophagoscopy with biopsy is necessary to confirm the diagnosis. The cell smear method is also employed. A lesion diagnosed as a stricture that is treated by dilatation should be carefully followed by roent-

genograms and esophagoscopy. Dr. Gabriel Tucker has been able to confirm the diagnosis of carcinoma by esophagoscopy and a biopsy or Papanicolaou cell smear method in all of the patients upon whom we have operated.

The usual early symptom of dysphagia is a warning symptom. Seventy-five per cent of the cases have some degree of dysphagia.⁴ Pain usually denotes a late lesion that is ulcerated or obstructing. However, an occasional case is encountered that has had substernal pain or cramp in the suprasternal notch without dysphagia. Some patients may have had for several weeks only a minor difficulty in swallowing, others may have a rapid onset of complete obstruction.

Lesions in the upper third of the esophagus may give rise to a most troublesome cough due to regurgitation of esophageal contents into the larynx. Therefore, a careful fluoroscopic and roentgen examination of the esophagus should be made when the lung fields do not demonstrate a definite causative factor. We must reduce the number of advanced cases with boring pain in the upper dorsal region, hoarseness due to involvement of the recurrent laryngeal nerve, or tracheo-esophageal fistula with secondary pulmonary suppuration. May I again repeat that the late cases can be markedly reduced in number if we will only employ the aid of the roentgenologist and the esophagologist at the very first sign of a disorder in the esophagus.

The squamous cell epitheliomas have a much slower rate of growth and metastasize later than do the adenocarcinomas. It is possible to anticipate a favorable result if these cases will come to surgery at an early date. With the recent advances in thoracic surgery it can now be said that an exploratory thoracotomy is almost as safe a procedure as an exploratory laparotomy. In the absence of evidence of metastasis, an exploration to determine the operability of the lesion is performed. Fixation of the growth to the hilus of the lung or aorta or extensive spread of the disease will be present in some cases. When

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 29, 1949.

it is possible to mobilize the lesion, resection even with the presence of metastatic nodules in the liver is well worth the effort to give relief from esophageal obstruction. This has been advocated by Sweet. At present we believe that, although our percentage of survivals beyond one year is small, it is far better than that offered by gastrostomy. The patients are again able to take food and usually gain in strength and weight and above all have a new and hopeful outlook rather than the miserable existence with a gastrostomy.

Our mortality rate is 25 per cent in 36 cases

to Jan. 1, 1949. Some of these represent extensive lesions or cardiovascular complications. There are two patients out of the series of 36 cases that are living two years following resection and one nearly three years.

The contributions made by Adams and Phemister,⁶ Garlock,⁷ Sweet,⁸ and others have made it possible to increase the scope of the operation at first performed on lesions at the lower end of the esophagus. During the past two years many clinics have reported successful operations on the middle and upper third of the esophagus. Res-



Fig. 1. Carcinoma involving the lower third of the esophagus.



Fig. 2. An extensive carcinoma in the upper third of the esophagus behind and above the arch of the aorta.



Fig. 3. The stomach and duodenum have been mobilized and the anastomosis completed high up in the left pleural cavity to the short proximal end of the esophagus.

toration of the continuity of the gastro-intestinal tract by an intrathoracic anastomosis to the lower segment of the stomach provides relief from the distress resulting from the obstruction produced by the growth. It is possible that the patient can be cured.

The esophagus is approached transpleurally, and in the lower lesion the distal end of the stomach is transected to form a tube that is brought up through the incision in the diaphragm and anastomosed to the esophagus well above the lesion.

Fig. 1 demonstrates a carcinoma in the lower third of the esophagus. This patient is symptom-free without evidence of recurrence or metastasis almost three years after operation. It is important to have an early x-ray record of the site of anastomosis in all gastro-intestinal surgery for comparison at a later date.

Fig. 2 illustrates a high lesion situated behind and above the arch, and Fig. 3 the position of the stomach and the anastomosis. The entire stomach was mobilized, preserving the right gastric and right gastro-epiploic vessels. The stomach was then brought up through the diaphragm to complete the anastomosis. In this instance two incisions were made, the lower one through the bed of the entire left eighth rib to complete the abdominal operative procedure through the incision in the diaphragm. The upper incision

was made through the bed of the anterior half of the fourth rib in order to complete the anastomosis at this high level. Cases have been reported from other clinics in which the anastomosis was actually performed at the pharyngo-esophageal junction. Fig. 4 illustrates a lesion that is not as extensive as many that we have encountered.



Fig. 4. Resected specimen shows a carcinoma that was situated above the arch of the aorta. There was no gross evidence of local spread of the disease. The lower end represents the small amount of stomach that is resected in the higher lesions.

The preoperative and postoperative care is most important. When complete obstruction is present, it is at times deemed necessary to do a preliminary jejunostomy for the administration of feedings over a period of ten days to two weeks prior to operation. Most of the patients can be prepared with intravenous feedings and blood. These patients require the care of an internist as well as a surgeon, and it is the combination of such care that allows a radical procedure to be performed. Chest complications such as atelectasis, pleural effusion, and pneumonia do occur postoperatively and like all major operative procedures require constant and careful supervision.

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Choice and Use of Chemotherapeutic Agents in General Practice

EDITOR'S NOTE: Under the above title we have been permitted to publish several summaries from a paper read by John A. Kolmer, M.D., at the 1950 Postgraduate Institute of the Philadelphia County Medical Society. The final summaries are appended. Dr. Kolmer comments:

"While a large number of sulfonamide and sulfone compounds are available, yet clinical experience has more or less clearly defined their choice in the treatment of various bacterial infections. Furthermore, until the discovery of aureomycin, chloramphenicol (chloromycetin), and bacitracin, antibiotic therapy of infectious diseases was merely a choice between the administration of penicillin, streptomycin, or both. Nowadays, however, accurate clinical and/or laboratory examinations, along with clinical experience, are more important than ever in the choice of the antibiotic or combination of two or more chemotherapeutic compounds to be employed in the treatment of bacterial, spirochetal, rickettsial, and viral diseases."

8. Blood Level Assays of Sulfonamide and Antibiotic Compounds in Chemotherapy

These are not ordinarily required unless indicated by unsatisfactory therapeutic results.

Chemical assays of the sulfonamides are much more accurate than biologic assays of the antibiotic compounds.

In acute infections of moderate and severe degree it appears advisable to maintain blood levels of antibiotic compounds four to eight times higher per cc. of plasma than the minimal bacteriostatic concentrations per cc. of culture medium.

Blood for plasma assays should be collected just before the next dose of compound is to be administered.

9. Carinamide in Penicillin Therapy

Oral administration of 2 to 3 Gm. (4 to 6 tablets) every three hours increases blood levels. It may be administered intravenously dissolved in penicillin solution.

It is advisable when penicillin in aqueous solution is employed in the treatment of severe infections and especially in penicillin-resistant infections.

It is ordinarily well borne without serious toxic effects, although oral administration may be difficult or impossible in severely ill patients because of nausea with or without vomiting.

It is not ordinarily required when repository penicillin products are administered (procaine penicillin, penicillin in peanut oil and beeswax, S-R penicillin).

13. Combination Chemotherapy

(Synergistic or Additive)

This consists of the simultaneous administration of two compounds. In some instances the effects appear to be truly synergistic, while in others they are merely additive.

It is frequently indicated in the treatment of severe infections like the septicemias, meningitides, pneumonias, endocarditides, etc.; likewise in the treatment of mixed infections and those due to resistant organisms.

It tends to reduce the incidence of acquired resistance of bacteria.

Usually there are no contraindications from the standpoint of toxic reactions.

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EDITORIALS

THE SURGICAL SECTION OF THE SCIENTIFIC PROGRAM

A feature of this year's program is an increase in the number of combined meetings in which both the medical and surgical aspects of a subject will be presented. This is done not only for the benefit of the general practitioner but for the various specialists, in order that a well-rounded view of a given subject may be obtained at one sitting. Some of the subjects which are to be covered are hepatic cirrhosis, pulmonary tuberculosis, the present status of antibiotics, peripheral vascular disease, and ulcerative lesions of the bowel. Such widely known surgeons as Drs. Robert R. Linton, Richard B. Cattell, and Richard H. Overholt, of Boston, and John S. Lockwood, of New York, will take part in these symposia.

The meetings of the Section on Surgery, which are held separately, are also designed primarily for the general practitioner. In dealing with specific diseases, the surgeon endeavors to point out what can and should be done for the patient. Some of the section periods are set up as symposia, but others cover several unrelated subjects.

There will be a full period devoted to the hand on Tuesday morning, during which the commonplace infections and acute injuries will be dis-

cussed, as well as more serious burn and reconstructive problems. Dr. Sumner L. Koch, of Chicago, will take part in this symposium.

There will be a symposium on abdominal surgery on Tuesday afternoon. Much of this will be devoted to acute conditions within the abdomen, a problem with which the practitioner is constantly faced. A feature of this program will be a paper by Dr. Francis D. Moore, of Boston. Dr. Moore has reviewed a large series of patients with duodenal ulcer seen at the Massachusetts General Hospital and compared the long-term results obtained by definitive surgery as opposed to the results in those patients who chose to continue on a medical régime.

Also on Tuesday afternoon there will be a period by the Section on Surgery dealing with unrelated subjects of common interest. Dr. Stuart W. Harrington, of the Mayo Clinic, will be the featured speaker and will discuss the management of mediastinal tumors. On Wednesday morning Dr. Frank Lahey, of Boston, will discuss the advisability of doing total gastrectomy in all cases of carcinoma of the stomach in an effort to increase the rate of cure. On Wednesday afternoon there will be a symposium on the management of low back pain, a problem which constantly faces the medical profession. That afternoon the clinicopathologic conference will be

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

held. These conferences are always stimulating.

All of the surgical specialties will be represented at some time on the program. Dr. Richard B. Cattell will conclude the surgical program on Thursday morning with a discussion of benign lesions of the pancreas.

JULIAN JOHNSON, M.D., *Chairman,*
STUART N. ROWE, M.D., *Secretary,*
SURGICAL SECTION.

CHILDHOOD FEEDING

(EDITOR'S NOTE: This is the fourth of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania.)

Within the past few decades there has been a most impressive decline in the mortality and morbidity rates in young children. No one factor has been wholly responsible for this conservation of tomorrow's American citizens, but it is well established that a better understanding of nutrition has been exceedingly important. This applies to the pregnant woman, the newborn, the infant, and the child of preschool age.

Present-day prenatal care is in a large measure concerned with the optimum intake of essential foods by the expectant mother. A satisfactory diet for the expectant mother must particularly provide adequate calcium and proteins. Milk and milk products are of first importance, but generous amounts of meat, eggs, vegetables, and fruit are also indicated. If such a diet is taken, the vitamin and mineral requirements will probably be covered. Present-day practice, however, usually includes as safeguards additional iron, calcium, vitamin D, and vitamin C. It is well to emphasize that both for the expectant mother and for the child after birth as many of the accessories as possible should be received in the form of food rather than medicine.

After birth the first decision to be made concerns the choice of breast or artificial feeding. Much can be said for both forms. It will suffice here to say that with a great majority of full-time babies breast feeding has much in its favor. In the care of premature babies, it is frequently more practical to use some form of artificial feeding, either alone or combined with breast milk. This is true because of the greater flexibility possible from day to day with artificial feeding to meet the varying demands.

Assuming that the newborn is to be fed artificially, four essentials are to be particularly con-

sidered: namely, protein, calcium, vitamin C, and vitamin D. In regard to the latter, practically all infants need 400 to 500 units of vitamin D daily. It is a question whether doses greatly in excess of this are of value or even desirable in the average case. Vitamin C likewise is most important. The thought at present is to delay orange juice until the child is 2 or 3 months old. Within the first few days of life it is well to begin the cod liver oil and also 25 to 50 mg. of ascorbic acid. This applies to the breast-fed as well as the artificially fed baby.

During the first months of life, approximately 1½ ounces of milk per pound of body weight each day will supply the basic needs for calcium and protein. During the early months of life, there is frequently a relative anemia in babies. If this is marked, medicinal iron may be needed. Usually cereals can be introduced at least at 2 to 3 months of age, vegetables at 4 months, and strained meats at 5 to 6 months. A generous intake of these foods will usually provide sufficient iron from food sources. It is well, however, to keep in mind the possible need of additional iron, as a rule in the form of one of the ferrous salts; 2 to 6 grains daily according to age will be adequate. Iron is preferably administered at a time when the stomach is relatively empty.

Orange juice when first given to the baby is best offered in not over teaspoonful amounts, well diluted with water. It can be gradually worked up to 3 ounces or more of fresh juice daily. When the baby takes this amount of fresh juice, a generous allowance of vitamin C is thereby provided. If satisfactory amounts of fresh juice are not well tolerated, ascorbic acid should be continued as a supplement. It is important to remember that orange juice should be given soon after extraction, as it loses much of its C content after the first hour. Usually sufficient of the B complex factors will be included in the cereals, vegetables, and meats.

Throughout childhood, up until school age, it continues to be important to offer a variety of foods. Milk should always be considered of primary importance, and the child beyond the infancy period needs at least 1½ pints to a quart daily. Emphasis should still be maintained upon fruits, eggs, meats, and vegetables. Practically all children need some form of vitamin D during their first six years of life.

It is well to remember that too great an issue should not be made by the parents of the requirement that a child take a specific amount of food

at a particular time. Too much stress on details may have the opposite effect from that intended. Frequently an apparent indifference on the part of the parents relative to eating habits is very effective. The amount of food taken over a period of weeks rather than in a particular day is the important detail.

The reader's attention is called to the very excellent monograph by Jeans in the March 18 issue of the *Journal of the American Medical Association*.

JOHN M. HIGGINS, M.D.

COOPERATION PLUS

The 11,200 members of The Medical Society of the State of Pennsylvania are receiving periodically the Pennsylvania Department of Health edition of the *Cancer Bulletin*, which is published bimonthly by the Medical Arts Publishing Foundation of the University of Texas Hospital for Cancer Research.

Each issue is very attractive in appearance and readily readable in format. Its editorial staff includes, in addition to doctors of medicine, doctors of philosophy, registered nurses, artists and photographers, and its advisory editorial board from many states lists Drs. Catharine Macfarlane and Eugene P. Pendergrass of Pennsylvania.

Each issue is graphically illustrated, principally with photographs in color which are related to brief articles most of which will help the doctor who first sees the precancerous or the early cancer patient to administer prompt and adequate preventive or cancer treatment—in a sentence—to detect cancer early, in the physician's office or by following his insistent advice to promptly consult others.

This instrument of instruction, the *Cancer Bulletin*, will reach all members of The Medical Society of the State of Pennsylvania during the next twelve months through the cooperation of (1) the Cancer Division of the Pennsylvania Department of Health, which pays for the processing of the bulletin in Texas, and (2) the Commission on Cancer of The Medical Society of the State of Pennsylvania, which pays (a) the cost of expressing the bulletins from Texas to Harrisburg and (b) the postage and handling

which are necessary to mailing the *Cancer Bulletin* to our membership. The total cost to the State Society of these two items is approximately \$1,500 annually.

It is the hope of our Board of Trustees that each member will show this handsome bulletin, as it arrives in his or her office, the respect and regard to which it is entitled in the furthering of the best health interests of the people throughout Pennsylvania.

KEYSTONES OF PUBLIC HEALTH FOR PENNSYLVANIA

Environmental Sanitation

(EDITOR'S NOTE: This is the seventh of a series of guest editorials planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.)

This chapter, the longest of the report, comprehensively covers those sanitary activities of the Health Department pertaining to air, water, soil, milk, food, sewage, solid wastes, and animal and insect disease carriers. The chapter is critical of these activities insofar as they are understaffed, are carried out by untrained personnel to a great extent, are done piecemeal by several agencies both within and outside the State Health Department, and are more centralized than good public health practice demands.

The report recommends that a single central unit be set up so that all environmental sanitation functions would be under the direction of a single administrator. This new unit would encompass functions of the present Division of Environmental Hygiene and the Bureau of Sanitary Engineering. It would be large enough to justify an approximate doubling of professional staff, and would have an administrative subdivision responsible for correlation of all office and drafting-room personnel and laboratory functions. The chief of this over-all sanitation service would cooperate closely with other department heads within the Health Department and be included in staff meetings dealing with general Health Department policies. He would also cooperate very closely with the Division of Industrial Hygiene in the Bureau of Health Conservation, which is described as an extremely valuable State service to nearly two million industrial em-

ployees and should be considerably expanded by use of State funds, thus releasing Federal funds for extension of program.

During the period of reorganization, a competent clerical staff should be employed and the present sanitarian assistants, for the great part unqualified to perform technical functions, should be provided with designated headquarters, be under the supervision of qualified supervisors, be given training to do their jobs intelligently, and be forbidden to hold both a full-time job in the Department of Health and a full-time job in other work. During the reorganization, salaries and personnel qualifications should be critically examined so that proper adjustment can be made and an intensive program of pre-service, in-service, and academic training of all sanitation personnel should be put into effect. The report further recommends that training courses be set up so that operators and employees of water treatment plants, sewage treatment plants, milk plants, swimming pools, food handling and other establishments, would be given the advantage of newer techniques in their respective fields. The general public should be made aware of all phases of environmental sanitation by means of pamphlets and other educational material.

The report makes specific recommendations for certain aspects of the general sanitation program. It recommends that the various agencies responsible for water supply operate under a written statement of policy clearly delineating responsibility of each agency; that there be similar agency correlation to prevent duplication and overlapping in food control functions; that the several responsible agencies cooperate with regard to sewage disposal activities; and that a manual of procedure be formulated so that uniform practices may be employed.

Insofar as nuisance investigations constitute a great part of the environmental sanitation load, investigation of nuisances should be correlated with positive programs of control and supervision, with special emphasis on putting into effect a positive program of municipal garbage and refuse disposal.

The report states that swimming pools are poorly regulated and that restaurant sanitation is in a relatively primitive state and that school

sanitation personnel lack proper equipment. It further states that minimum services pertaining to insect and rodent control should be materially increased with the addition to the staff of a well-qualified public health engineer to be responsible for vector control, this engineer to be aided by a well-trained veterinarian whose responsibility should be the animal diseases transmissible to man. It also recommends that the sanitary regulations for tourist camps be made a function of the State Department of Health and that the Bureau of Environmental Sanitation assume responsibility for camps, housing, and community planning with a Division Chief assuming charge of these activities which should be defined in a written statement of policy.

Milk control facilities are described as inadequate insofar as the standards set for bacterial content of pasteurized milk are far less safe than those generally accepted and insofar as the control staff is quite incapable of doing an adequate inspection job. Although records are poorly kept, and thus it is not possible to give many facts or figures, the report indicates that plant producer farms are visited on the average of once each eleven years. In spite of this sort of State failure, only ten cities and boroughs in the State are allowed to enforce municipal milk ordinances. Despite expressed willingness and apparent ability to adequately enforce milk control measures, Pittsburgh is not allowed to do so by the State Department of Health. This sort of poor administration is sharply criticized in the report which states: "It is only exceptional circumstances that justifies the direct supervision of milk plants by the State Health Department . . . better supervision can be obtained through the activities of a strong local health service."

In general, the report leaves the impression that there is room for a great deal of improvement in environmental sanitation activities.

It recommends reorganization, modern personnel practices and, above all, a fitting in of environmental sanitation efforts of the State Department of Health into a well-rounded local health setup.

I. HOPE ALEXANDER, M.D., *Director*,
Department of Public Health,
Pittsburgh, Pa.

United Mine Workers of America Welfare and Retirement Fund

Information for Physicians

Form 105-HS (Revised 7-1-50)

I. General Instructions

These instructions relate to the provision of medical care benefits for members of the United Mine Workers of America, their wives, and their dependent children who have not reached their eighteenth birthday. The Area Medical Office will furnish specific information not included in these instructions which are intended to provide general information only.

A. Identification

Members of the United Mine Workers of America and their dependents must show you Form 85-HS to obtain service at the Fund's expense. This form lists the names of the member, his wife and his dependent children under 18 years of age. Please note that only those dependent children under 18 years of age may receive benefits. The birth dates of all children are listed on the form to enable you to determine whether a child has reached his eighteenth birthday. This form must bear the seal of both the District and Local Union. It must be signed by the member and his wife before you accept it as evidence of eligibility for service.

A child born after the member gets his Form 85-HS is eligible to receive the hospital and medical care herein described, even though his name does not appear on the Form 85-HS.

A widow and her children are not eligible to receive service. The benefits herein described are available only during the lifetime of the member.

B. Services

Services may be provided at Fund expense only by hospitals, physicians, and other individuals with whom the Fund has made specific arrangements for such service, or when services are authorized in advance by the Area Medical Office.

1. Hospitalization

The Fund will reimburse hospitals for ward or semi-private accommodations unless the condition of the patient is such that a private room is necessary. If the patient insists on private accommodations when not medically indicated, the patient must be responsible for any difference in cost. All necessary services may be provided except:

- a. Obstetric service—unless such service is medically indicated and is authorized in advance by the Area Medical Office. The Area Office will advise you concerning the information which must be submitted to secure such authorization.
- b. Tonsillectomies and adenoidectomies—unless such service is authorized by the Area Medical Office. The Area Office will advise you concerning the information which must be submitted to secure such authorization.
- c. Care of mental illness after diagnosis has been established.
- d. Services which the patient can receive from other agencies, either voluntary or governmental.
- e. Services which the employer or another third party is legally obligated to provide.
- f. Personal services such as telephone calls, radio, etc.

2. Professional Services in the Hospital

The Fund will pay the cost of necessary medical care in the hospital when patients are hospitalized in accordance with the provisions listed above.

3. Out-patient Hospital Care

Services may be provided in the out-patient department of a hospital in accordance with specific arrangements established between the Area Medical Office and the individual hospital.

4. Specialist Service

Patients requiring the service of a specialist may be provided such service when it is authorized in advance by the Area Medical Office. The Area Office will advise you concerning the information which must be submitted to secure such authorization.

5. Dental Care

The Fund will pay for dental services incident to the hospital care of a patient, and those which contribute toward any illness which may necessitate hospitalization. Such dental care must be authorized in advance. The Area Medical Office will advise you concerning the information which must be submitted to secure such authorization.

6. *Eyeglasses*

The Fund will pay for eyeglasses in those cases necessitated by surgical procedures involving the eyes.

7. *Prosthetic Appliances*

Physicians who prescribe orthopedic and similar appliances may request the Area Medical Office to furnish them the names of suppliers with whom arrangements have been made for the purchase of such items.

8. *Emergencies*

In the event of an unquestionable emergency, the Fund will reimburse any hospital or physician at reasonable rates for services rendered its beneficiaries which are within the scope indicated above. Eligibility must be established as soon as possible. The Area Medical Office should be notified within 24 hours of admission of the patient and should be given factual information upon which the emergency character of the case is based.

II. *Submission of Bills and Reports*

The physician will use the Fund's Invoice and Report Form 101-HS (Revised 7-1-50) or Authorization Form 84-HS (Revised 7-1-50) for billing. The following are the instructions for the preparation of these forms:

1. The member's social security number, District and Local Union numbers, and the patient's name must be listed as shown on the member's Form 85-HS.
2. The spaces for birth date, and minor or dependent must be completed.
3. Discharge diagnosis and surgery performed must be entered.
4. "Patient was hospitalized": All appropriate blanks must be completed in this block. The date of admission, discharge, or transfer is particularly important.
5. If this is a bill for professional services provided in the hospital, the name and address of the hospital must be entered in the appropriate space.
6. The invoice must have the date of service or inclusive dates of services rendered.
7. The type of service rendered must be clearly stated.
8. The patient's signature is not mandatory on bills submitted for a physician's services. It must be on invoices submitted for hospitalization.
9. The vendor's certificate must be signed.
10. The original (with stub attached) and duplicate are to be submitted to the Area Medical Office. The triplicate is for the physician.
11. Payment will be expedited if the invoice is submitted in sufficient detail to permit its prompt approval. Whenever it is necessary for the Area Medical Office to return an invoice for additional information, there is a material delay in payment.

PLEASE NOTE—IMPORTANT

Please submit bills promptly. It will be assumed that any material delay in submission of your bills is evidence that you are not concerned about prompt payment. Bills submitted promptly will be given priority in processing and payment.

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OFFICERS' DEPARTMENT

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8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

CALL TO 1950 MEETING

The first meeting of the House of Delegates of The Medical Society of the State of Pennsylvania will be called to order in the Clover Room, Bellevue-Stratford Hotel, Philadelphia, Monday, Oct. 16, 1950, at 10 a.m. Subsequent sessions will be held as decided by the House, except the session for the election of officers on Wednesday morning.

Notice relative to parliamentary requirements for consideration of proposed amendments to the Constitution and By-laws was published in the May JOURNAL.

Proposed amendments to the Constitution and By-laws will be found on page 633 of the June JOURNAL.

FIFTY YEARS OF SERVICE

In the year 1950 the members of The Medical Society of the State of Pennsylvania whose names appear on the appended list received a handsomely mounted plaque from their state society in public expression of the esteem in which each is held because of his or her "50 years of medical service to his community in the traditional ideals of the profession."

Since 1933 the formal presentation of these citations at the several councilor district meetings held annually throughout the State has been the outstanding event, and the luncheon or dinner table at which our "50 year members," accompanied by family members, were honor guests has been the center of attraction.

This form of recognition, which has been warmly received by the press and radio, has warmed the heart each year of forty to eighty practitioners, many of whom continue in their professional service.

First Councilor District

PHILADELPHIA COUNTY:

Eleanore F. Boulton	John E. Hume
Nelson M. Brinkerhoff	Edward George Muhly
Ralph Butler	Francis W. Sinkler
Howard C. Carpenter	Myer Solis-Cohen
William H. Chandlee	E. Quintard St. John
William G. Eisenhardt	Walton C. Swindells
Howard G. Fretz	Mervyn R. Taylor
Charles J. Hatfield	John K. Walker
Smith Hamill Horne	Warren Walker

Second Councilor District

BERKS COUNTY: Ralph L. Hill

CHESTER COUNTY: William D. Schrack, Sr.

MONTGOMERY COUNTY: Wallace W. Dill

George T. Lukens

Third Councilor District

CARBON COUNTY: Clinton J. Kistler

LACKAWANNA COUNTY: William A. Coggins

MONROE COUNTY: William R. Levering

NORTHAMPTON COUNTY: Clinton F. Stofflet

WAYNE-PIKE COUNTY: Clifford H. Mack

Fourth Councilor District

COLUMBIA COUNTY: William C. Hensly

MONTOUR COUNTY: Vincent J. Cassone

NORTHUMBERLAND COUNTY: Henry F. Ulrich

SCHUYLKILL COUNTY: Francis M. Dougherty

Fifth Councilor District

CUMBERLAND COUNTY: Seth I. Cadwallader

LANCASTER COUNTY:

Benjamin F. Good	Charles P. Stahr
George B. Hershey	John L. Atlee, Sr.*

Sixth Councilor District

BLAIR COUNTY: Joseph D. Findley *

JUNIATA COUNTY: Francis A. Stiles

Seventh Councilor District

None.

* Posthumously.

Eighth Councilor District

ERIE COUNTY: Guy C. Boughton

MERCER COUNTY:

James F. Elder	William H. Phillips
Clifford C. Marshall	William W. Wyant

Ninth Councilor District

BUTLER COUNTY: Harry R. Wilson

Tenth Councilor District

ALLEGHENY COUNTY:

Walden A. Clark	William B. Ray
Walter G. Goehring	Wilton H. Robinson
Walton W. Martin	David W. Seville
Hugh E. McGuire	Olive B. Steinmetz
George T. McNish	Charles J. Stybr
(51 years)	Martin C. Taylor
Isaac L. Ohlman	Edward V. Weller
George W. Rall	Charles E. Ziegler *

BEAVER COUNTY: Charles S. McGeorge

WESTMORELAND COUNTY: Charles B. Ambrose
John D. Greaves

Eleventh Councilor District

CAMBRIA COUNTY: Clarence M. Harris
Emlyn R. Jones

WASHINGTON COUNTY: John C. Kelso
James W. McKennan

Twelfth Councilor District

LUZERNE COUNTY:

Charles L. Ashley	Robert O. Koons
Herman A. Fischer	Patrick A. McLaughlin
August G. Hinrichs	Daniel G. Robinhold

THE AMA ADVERTISING CAMPAIGN

The Board of Trustees and the Campaign Coordinating Committee of the American Medical Association have approved a nation-wide advertising program which will include three principal media—newspapers, magazines, and radio.

A total advertising budget of \$1,110,000 has been approved by the AMA Board of Trustees with \$560,000 allocated to newspapers, \$300,000 to radio, and \$250,000 to national magazines.

Whitaker & Baxter, directors of the AMA's National Education Campaign, stated that this action was taken to bring the efforts of the campaign to a climax in October by crystallizing public sentiment on the issue of voluntary versus compulsory health insurance.

The newspaper advertising schedule calls for

* Posthumously.

blanket coverage of every bona fide daily and weekly newspaper in the United States, totaling approximately 11,000, and the copy is scheduled to run during the week of October 8. Newspapers in the territories of Hawaii and Alaska will be included in the schedule. The space reservation will approximate 70 inches in all papers.

About thirty of the leading national magazines and a score of advertising trade publications will be included in the magazine advertising program.

The radio advertising program calls for an intensive "spot announcement" campaign, utilizing time on some 300 radio stations, covering every state and Hawaii and Alaska.

The magazine and radio campaigns also are scheduled for October.

The decision to follow this course of attack was based on the following factors:

1. In order to relieve the medical profession of any necessity for a continuing, exhaustive campaign for survival, it is imperative to find a way to bring the issue of government-controlled medicine to a public conclusion.

2. The most desirable action possible, naturally, would be a vote in Congress—and that conclusion we are thoroughly prepared for, and would welcome.

3. However, the issue will not be permitted by its sponsors to emerge in this Congress, and we are forced to find other means to solidify medicine's position.

4. Medicine, in its National Campaign, has won the support of the greatest cross-section of public sentiment ever amassed on a controversial public issue in this country. Medicine and its allies have proved to millions of people and to thousands of publicly responsible organizations that the problems of medical service, care, and cost can be solved under the voluntary system without Federal controls.

5. The need now is to crystallize that general public sentiment into concrete public certainty.

6. The need is to prove that if a general election were called on the issue of compulsory health insurance, the people would vote "No!"

7. The need is to show that compulsory health insurance is discredited in the eyes of most Americans, and that the benefits of voluntary health insurance are more firmly established day by day.

8. The need is to build and solidify the confidence of the public in the medical profession.

9. The need is to build the confidence of doctors in their own leadership—local, state, and national—and in their own ability to solve their problems.

Doctors and their allies have done a spectacular job of turning the tide which would have destroyed the profession.

In directing the National Campaign, whose success 18 months ago looked pretty disheartening, the AMA Board of Trustees and Coordinating Committee have earned the sincere respect of leaders in business, industry, and other professions for their forthright battle against the threat of socialism. On this basis, medicine's crusade has won recognition as a service to the entire nation.

10. For its effect on future political events affecting the profession, the respect and esteem that medicine has won needs to be pointed out to the nation at large. It needs to be crystallized into a firm foundation of strength, which medicine well may need in the future. It needs to be capitalized at its height—toward the nullification of the efforts of those who will continue to try to discredit medicine.

The advertising program is geared to accomplish the above factors and many more. Above all else it will strive constructively to solidify the position and build the prestige of the profession generally, and since the finality of a Congressional vote is denied medicine at this time, it is our intention to end this campaign with the conclusiveness of the people's mandate which we know we have.

The *Journal of the American Medical Association* for June 24 contains an editorial which reads in part:

"Some members of the medical profession and others may look with askance at any efforts of the profession to resort to advertising. However, the projected program is not advertising in the normal sense; it is not intended to permit preening in the light of self-accomplishment. It is intended to forcefully convey information to everyone who should be interested in health. Briefly, the campaign is intended to relieve the medical profession of the need for a continuing exhaustive campaign and to find a way to bring the issue of government-controlled medicine to a public conclusion, to crystallize general public sentiment into concrete public certainty, and to solidify the confidence of the public in the medical profession and to focus attention on what

the profession has done and can do without government domination.

"If physicians have confidence in their own leadership—local, state, and national—and their ability to solve their problems, they can continue the spectacular job they have done in aiding medical progress and in holding back the forces which would shackle the medical profession and bring the general population to its knees before bureaucrats. From past experience, physicians have shown themselves capable of approaching their problems practically. They now are faced with a need for similar understanding. With their support the new phase of the National Education Campaign will reach its objectives. And the campaign should have the support of every physician. If there are questions on the part of members, they should be forwarded to their local or state societies or to the American Medical Association for answer. These questions, if troublesome, should not be left unanswered, as there is too much at stake for the people of this nation."

COMMUNITY EMERGENCY MEDICAL CALL SERVICE

Continuing the series of reports on the above subject as read at the 1950 Secretaries-Editors Conference and printed in the May and June PENNSYLVANIA MEDICAL JOURNAL, we offer herewith two additional reports.

Philadelphia County

The society through its executive office has been rendering emergency medical service during the daytime, and in most instances during the night, for a number of years. However, it has been the feeling of the officers of the society in recent months that this service should be expanded and that an official list of the names of physicians willing to provide this service should be prepared covering all sections of the city.

Towards this end a request for volunteers was made to our membership by direct mail, in our society bulletin, as well as through our five branch societies. After several months of effort, we finally secured a sufficient number of physicians to warrant a public announcement of the availability of a 24-hour emergency medical service under the auspices of the society.

This service began officially on Monday, Feb. 20, 1950, and has been working very smoothly. Up to the present time approximately 100 calls have been received.

Arrangements were made with a recognized commercial telephone answering service to handle incoming calls in the name of the society by means of a special telephone number registered in our name, and with a

number assigned to it which could be easily remembered by the public. The names of the physicians agreeing to render the service, arranged in geographic districts, were turned over to the answering service. The exchange contacts a physician located in the vicinity of the call and arranges for him to render the service required. Tabulated reports of all incoming calls are made to the society by the exchange for statistical purposes. The society pays for the telephone line as well as the service fee to the exchange.

Announcement of the service was made in all local newspapers, radio stations, and through the Department of Public Safety for transmission to the various police districts. We are planning to run paid advertisements in the local newspapers as a reminder to the public of this service. Arrangements are also being made to place a paid advertisement in a prominent space in the classified telephone directory.

We have advised the public that the service is not a free one and that those persons able to pay for medical care are expected to pay the physician making the call on the basis of his own stipulated fee. However, we have also stated publicly that no one will be denied the service because of inability to pay for medical care.

We have encouraged persons needing medical care in an emergency to endeavor first to reach their family doctor before using the facilities of our service.

We feel confident that the service will meet a public need and that one of its by-products will be improved public relations between the profession and the laity.

We have not attempted deliberately to establish professional fees to be charged by the physicians cooperating in the service, as we felt that this was a matter to be handled directly between the physician and the patient.

Westmoreland County

There are three small cities in Westmoreland County which may have emergency call problems. The first is a highly industrialized one, which depends entirely on a nearby hospital outside our county. From this city there has been no complaint and, so far as I know, no problem exists. It is a very compact community.

The second city, somewhat similarly industrialized as the first, uses the sole hospital as a nucleus for emergencies. There is no organized emergency service, but that central institution has and continues to be the logical center where physicians can have phone numbers listed when absent from home and where most emergencies are referred.

To meet the demand for emergency service in the third city (county seat), a private phone exchange was set up and financed by approximately 20 physicians in June, 1949. This was done because the hospital administration flatly refused to take calls and relay messages outside the institution. They said the exchange was already overcrowded. The private exchange has not worked out very well and is somewhat of a failure. Currently, the staff is trying to get reconsideration by the hospital so that the natural center of medical care in the community will accept and transfer emergency calls. This would simplify the problem, and any added expense would be much less than the physicians themselves are already contributing.

ATTENTION, SCHOOL EXAMINERS

The many physicians who serve as school medical examiners assume a great responsibility to the pupils and their parents throughout the Commonwealth.

With the hope of increasing their zeal and interest in this phase of their professional service and as a means of bringing to the attention of all JOURNAL readers the ever growing importance of the health of school children, we offer the following regarding the American School Health Association and its *Journal of School Health*:

Physicians actually making medical examinations of pupils or those interested in the school health program should take advantage of the opportunities offered by the American School Health Association, which publishes the *Journal of School Health*. This alone is worth the annual membership fee of \$3.00. During the past year articles on diversified school health topics that have been published include "Why School Health Examinations?"; "Board of Education Support of School Health Services"; "Rheumatic Fever and the School Child"; "The School Physician in 1960"; "Does Television Damage the Eyes?"; "A School Health Advisory Council That Works"; "School Health Personnel—The Physician."

School physicians who wish to take advantage of the opportunity to join this organization and to receive its publication, *Journal of School Health*, should forward their name and address—enclosing \$3.00 for annual membership dues and the *Journal* for one year—to A. O. DeWeese, M.D., Secretary-Treasurer, Kent State University, Kent, Ohio.

SYMPOSIUM FOR RESERVE MEDICAL OFFICERS

To keep military reserve medical officers of the Armed Forces (Army, Navy, and Air Force) posted on the latest developments in the field of medical science, a medico-military symposium for officers of the Fourth Naval District will be held at the U. S. Naval Hospital, Philadelphia, from October 23 to 28.

Commodore Richard A. Kern, MCR, USNR, professor of medicine at Temple University School of Medicine, and chairman of the symposium general committee, has announced that Rear Admiral Clifford A. Swanson, MC, USN, Surgeon General of the Navy, will open the meetings with an address on "The Physician as a Naval Officer."

Officers attending the symposium will be welcomed by Rear Admiral Roscoe E. Schuirmann, commandant of the Fourth Naval District; Brigadier General Leonard E. Rea, USMC; Captain Clyde W. Brunson, MC, USN, commanding officer of the Philadelphia Naval

Hospital; and Captain James R. Thomas, Fourth Naval District medical officers.

Speeches and panel discussions are scheduled in aviation medicine, national defense in case of disaster or attack, national preparedness, psychiatry, submarine medicine, surgery, and orthopedics. Physicians selected to head the panels include Brig. General James P. Cooney, chief of Radiology Branch, Division of Military Application, Atomic Energy Commission; Dr. Perrin H. Long, professor of medicine at Johns Hopkins University; Captain John R. Poppen, MC, USN; Captain George Lyons, MC, USN; Rear Admiral C. J. Brown, MC, USN; Captain Charles W. Shilling, MC, USN; Dr. Francis J. Braceland, Dr. Joseph Hughes, Dr. Edward A. Strecker, and Dr. Christian J. Lamberton.

It is urged that officers make hotel reservations well in advance, since no government housing facilities will be available. The final session of the symposium will be held Saturday morning, October 28, leaving the afternoon free for officers to attend the Penn-Navy football game.

The attendance at this symposium is not restricted to medical officers of the Armed Forces. All members of the medical profession are cordially invited to attend.

Sincerely yours,

M. H. PORTERFIELD,
Commander, MCR, USNR,
Assistant to District Medical Officer,
Naval Medical Reserve Program.

June 12, 1950

UNIVERSITY WOMEN CONDEMN SOCIALIZED MEDICINE

The West Virginia Division of the American Association of University Women, at a meeting at Jackson's Mill, May 20, 1950, adopted a strongly worded resolution condemning socialized medicine. This is the first state group of this national organization to take such action, and the West Virginia State Medical Association is again very proud of the fine work our auxiliary is doing in the drive to obtain resolutions.

It is interesting to note that our societies with auxiliaries have obtained on an average of *thirty* resolutions, while the societies that do not have auxiliaries have an average of but *nine*.—*News Letter*, West Virginia State Medical Association.

EXCERPTS FROM MINUTES OF BOARD OF TRUSTEES MEETINGS

May 11, 1950

The Board of Trustees of The Medical Society of the State of Pennsylvania met on Thursday, May 11, 1950, in the Governor's Room, Penn-Harris Hotel, Harrisburg.

Members in attendance were: Drs. Gilson Colby Engel (1st), John J. Sweeney (2d), Charles V. Hogan (4th), James Z. Appel (5th), Robert P. Banks (6th),

George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), and Thomas R. Gagon (12th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Malcolm W. Miller, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Allen W. Cowley (Public Relations), Dudley P. Walker (Medical Economics), John O. Bower (Acute Appendicitis Mortality), Howard K. Petry, and Messrs. Lester H. Perry, executive secretary, Leo E. Brown, executive assistant, and Robert L. Richards, staff secretary, all of the Harrisburg office.

The minutes of the meetings of March 2 and 3 were approved as circulated except for the deletion of a single word.

Reports of Board Committees

Finance Committee: Chairman Whitehill in his report referred to receipts, expenditures, and balances as found in the current financial statement of the Secretary-Treasurer which is each month mailed to the members of the Board. This was followed by the committee's recommendations for salary increases effective July 1, 1950, increasing the total of annual salaries from \$102,838 as of April 30 to \$105,876 as of July 31.

Increases were freely discussed and approved as recommended by a vote of six to three (6 to 3), the chairmen of the Board not voting. Dr. Gagon requested that he be recorded as voting in the negative.

This was followed by a motion duly seconded and carried to give due consideration to all salaries during the time of the 1950 annual convention.

The Finance Committee suggested that each member of the Board of Trustees discuss with local financial advisers the question of converting some of the Society's investments from U. S. Savings Bonds into other types of securities, and report on their findings at the July meetings of the Board.

Building Maintenance Committee: In the absence of Chairman Conahan, this report was read by Dr. Engel (see permanent record). The report was formally accepted, as was also the report of the *Library Committee*, copies of which had been previously distributed to members of the Board.

Reports of Medical Defense Cases

Second Councilor District—one case pending (No. 374).

Twelfth Councilor District—one case threatened.

Reports of Officers

President Samuel orally reported on his visit during the previous week to the 1950 session of the Medical Society of the State of New York, held in New York City. He also discussed his attendance upon the 1950 meetings of certain councilor districts and declared that in his opinion the attendance at these meetings did not seem to justify the continued planning of such programs or the expenditure of the state society funds involved.

After free discussion, a resolution was developed and

unanimously adopted which proposed an amendment to the By-laws (see page 633, June, 1950 issue of the PENNSYLVANIA MEDICAL JOURNAL).

Secretary-Treasurer Donaldson in his report (previously distributed) strongly recommended that the annual State Dinner be again held during the 1950 annual session, and that its control be kept as closely as possible in the hands of the members of the Board of Trustees. The report was unanimously adopted (see permanent record).

Executive Secretary Perry's report (previously distributed—see page 1) recommended that Mr. Stewart be also authorized to sign checks drawn against the \$1,200 revolving petty cash fund in the Harrisburg office.

The report was unanimously adopted.

The chairman of the Professional Liaison Committee of the Pennsylvania State Dental Society wrote a letter requesting the Board to meet with a similar committee from our society for the purpose of developing and continuing good relationships between the two professions. Chairman Klump was requested to reply appropriately.

Mr. Perry read correspondence from the State Department of Welfare, and from the executive director of the Pennsylvania Society for Crippled Children and Adults, Inc. (see permanent record). A letter from the executive secretary of the Dauphin County Medical Society was also read.

Report of Convention Manager (see p.r.)

Report of Commission on Acute Appendicitis Mortality

This report was referred to in the report of the Secretary-Treasurer and was previously distributed by Dr. Donaldson to the members of the Board (see p.r.).

On motion duly seconded and carried, \$1,000 was appropriated to the Commission on Acute Appendicitis Mortality for the purpose of underwriting a preliminary hospital survey, with the understanding that the Board of Trustees will request the 1950 House of Delegates to permit this sum to be refunded to the general checking account from the Society's endowment fund.

Report of Committee on Public Health Legislation

This report, previously distributed to the members of the Board of Trustees (see p.r.), was received with thanks.

Chairman Klump advised that H. R. bill No. 5865 now in Congress, providing Federal subsidies for local public health units, should be considered by the Board or by the Committee on Public Health Legislation in an attempt to have it brought out on the floor of the House.

On motion duly seconded and carried, the proposal was referred for appropriate action to the Committee on Public Health Legislation.

Report of Committee on Medical Economics

Chairman Walker read a communication (see p.r.) forwarded to him by Secretary-Treasurer Donaldson from the Veterans Administration proposing changes in the Society's existing contract with the V.A. He stated that the former chairman, Dr. Louis W. Jones, and the secretary considered the proposed changes satisfactory.

By unanimous vote the proposed alteration in the contract was approved and proper signatures authorized to be attached to the amended contract for return to the Veterans Administration.

Report of Committee on Public Relations

Chairman Klump announced that this report, copies of which had previously been distributed to the members of the Board, would be received if there were no objections.

Chairman Cowley of this committee advised that Chairman Fetter of the Committee on Emergency Disaster Medical Service would like to have a member of the Public Relations Committee on his committee. This was referred to Chairman Cowley. (SECRETARY-TREASURER'S NOTE: Dr. Frederic B. Davies, of Scranton, a member of both committees, has been accepted by Chairmen Cowley and Fetter for this assignment.)

On motion duly seconded and carried, the meeting adjourned at 11:45 p.m., to be reconvened the next morning at 9:15 a.m.

GEORGE S. KLUMP, M.D., *Chairman*,

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*.

May 12, 1950

The Board of Trustees reconvened Friday, May 12, 1950, in the American Room, Penn-Harris Hotel, Harrisburg, at 9:15 a.m.

Members in attendance were: Drs. John J. Sweeney (2d), Charles V. Hogan (4th), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagion (12th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Malcolm W. Miller, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Dudley P. Walker (Medical Economics), Pascal F. Lucchesi (Commission on Preventive Medicine and Public Health), Howard K. Petry, and Messrs. Lester H. Perry, executive secretary, Robert L. Richards, staff secretary, and A. H. Stewart, Jr., convention manager.

Chairman Klump called the meeting to order.

Report of Special Committee to Study Grievance Committee Project (see p.r.)

Chairman Jones reviewed the material previously distributed as a progress report without recommendations, but requested that the committee be permitted to continue its study. Permission was granted.

Unfinished Business (Vice-Chairman Gagion Presiding)

Progress Report of Commission on Preventive Medicine and Public Health

Chairman Lucchesi reviewed the March 3 progress report made by this commission on Keystones of Public Health for Pennsylvania. After an extensive discussion, the following actions were taken in sequence:

Chapter A, Appendix A—"Local Health Services"

It was moved and seconded that, after intensive study by various committees and this board, the Board of Trustees reaffirm its action regarding the Keystones of Public Health dealing with local units and system of hiring personnel as presented to the 1949 House of Delegates in Pittsburgh, and that it further approve the recommendation in "Keystones," Chapter A, entitled "Local Health Services," with the exception of the reference to Luzerne County. Dr. Whitehill cast a negative vote. Dr. Gagon in the chair did not vote.

CHAIRMAN GAGON: The chair will rule that any statements concerning Luzerne County in the reports should be deleted.

Chapter B, Appendix A—"Department of Health"

CHAIRMAN GAGON: Upon recommendation of Dr. Lucchesi, Chapter B of Appendix A will be referred to the Commission on Preventive Medicine and Public Health for additional study and report.

Chapter C, Appendix A—"Fiscal Administration"

Approved without discussion.

Chapter G, Appendix B—"Laboratories"

By unanimous motion Chapter G of Appendix B, "Keystones," entitled "Laboratories" was adopted as published.

Chapter H, "Public Health Statistics"

Unanimously adopted as published.

Chapter K, Appendix C—"Tuberculosis Control"

Approved as published.

Chapter L, Appendix D—"Venereal Disease Control"

Unanimously approved.

Chapter R, Appendix E—"Crippled Children's Program"

CHAIRMAN GAGON: Chapter R of Appendix E, entitled "Crippled Children's Program," is an incomplete report and is referred back to the Commission on Preventive Medicine and Public Health for further study and report at the next meeting of the Board.

Chapters T and U—Appendix F

Chapter T—"Adult Health" was unanimously approved.

Chapter U—"Environmental Sanitation" was unanimously approved.

Chapters P and Q—Appendix G

Chapter P—"Maternal and Child Health" was unanimously approved.

Chapter Q—"School Health" was unanimously approved.

New Business

Commission on Cancer (Progress Report)

Dr. Wesley D. Richards, chairman of the subcommittee on Education of the Commission on Cancer, appeared by appointment to request the Board to approve of the project of distributing the *Texas Cancer Bulletin* to the membership of The Medical Society of the State of Pennsylvania and assuming (1) only the costs to

express the bulletins from Texas to Harrisburg, and (2) pay the postage and handling charges necessary to mailing through the Evangelical Press of Harrisburg—the total cost to approximate \$1,500 annually.

By unanimous motion the budget of the Commission on Cancer is to be increased by \$1,500, which amount is to be earmarked and used for Distribution of the *Texas Cancer Bulletin* to the members of The Medical Society of the State of Pennsylvania.

Consideration of New Jersey State Society's Proposal to the 1950 AMA House of Delegates

Secretary Donaldson reviewed this resolution, previously distributed, which included a request that the AMA delegates from Pennsylvania be joint sponsors with the AMA delegates from New Jersey in presenting it to the House of Delegates of the American Medical Association in June, 1950.

Comments on the New Jersey Resolution

DR. GAGON: I feel that our AMA delegates should make a careful study of this request and that it should be referred to them in caucus.

DR. APPEL: Under *Program* on page 2 of the New Jersey resolution appears the following: "1. Voluntary non-profit insurance organizations should be used as the best means of budgeting hospital and medical service for the individual and his family." I feel that it would not be wise for the Medical Society to support such a policy.

DR. WHITEHILL: Under *Paragraph 12* I cannot approve the New Jersey position on the Federal subsidy of medical schools, and I note also that they ignored other publicized voluntary methods of writing insured medical services.

DR. KLUMP: *Section 10* on page 4 of the resolution says: "The need for better local public health service in most areas of the United States has long been recognized, but progress in providing it has been discouragingly slow. We recommend that every state government adopt such legislation as may be needed to permit consolidation of local health jurisdiction into districts having sufficient size and resources to support at least a minimum staff and facilities for complete modern basic public health protection." This appeared to be a controversial subject earlier this morning.

It was the consensus that this resolution from the New Jersey State Medical Society be placed in the hands of Dr. Appel, chairman of the delegates from Pennsylvania to the American Medical Association.

Informal Discussion on Appeal from Member from Eleventh Councilor District

This meritorious appeal, previously distributed, was discussed by Secretary Donaldson and Dr. Altmus, and it was decided that its disposition is definitely the responsibility of the county society concerned.

Report of Committee on Emergency Disaster Medical Service

Dr. Charles Wm. Smith discussed the report, previously distributed, which was prepared by Dr. Irwin M. Pochapin of the committee (see June PMJ).

It was moved, seconded, and unanimously carried that the Committee on Emergency Disaster Medical Service meet and do all that is feasible and possible to activate the program which they have presented to the Board of Trustees this morning, and that they report back to this board at its July meeting.

Election of Associate and Affiliate Members

Secretary Donaldson presented a list of the associate and affiliate members submitted by county medical societies for election (see permanent record).

It was moved, seconded, and unanimously carried that those named as nominees be declared elected.

Correspondence

Secretary Donaldson presented a resolution from the McKean County Medical Society (see permanent record).

It was moved, seconded, and unanimously carried that the proposal as expressed in the McKean County resolution be referred to our 1950 AMA delegates with a request for favorable consideration of its underlying principle.

Secretary Donaldson read a letter from Dr. Carl C. Fischer, chairman of the Commission on Child Health. After discussion, it was decided that this suggestion should be responded to by the Secretary in terms expressing the reaction to it by the 1950 Committee on Scientific Work.

Benjamin Rush Award

Chairman Klump appointed the following members of the Board of Trustees to serve as a committee on the 1950 Benjamin Rush Award of The Medical Society of the State of Pennsylvania: Drs. James Z. Appel, Francis J. Conahan, and Herman H. Walker.

Secretary Donaldson asked for approval to recommend to the committee that was elected to plan for the 1951 Secretaries-Editors Conference that Dr. Appel be accepted as adviser to this committee. This approval was granted.

Secretary Donaldson announced that the next meeting of the Board of Trustees will be held in Harrisburg on Thursday and Friday, July 27 and 28, 1950.

The board meeting was formally adjourned at 1:45 p.m.

GEORGE S. KLUMP, M.D., *Chairman,*

WALTER F. DONALDSON, M.D., *Secretary-Treasurer.*

MINUTES OF MEETING OF THE COMMISSION TO STUDY CONTROL OF RHEUMATIC FEVER

The Commission to Study Control of Rheumatic Fever of The Medical Society of the State of Pennsylvania met on Monday, May 8, 1950, at 12:15 p.m. in the Penn-Harris Hotel, Harrisburg.

Members present were: Drs. Andrew B. Fuller, chairman, Ralph L. Shanno, co-chairman, Allen W. Cowley, Constantine P. Faller, James R. Kitchell, Paul B. Kreitz, and Thomas P. Tredway. Mr. Robert L.

Richards, staff secretary to the committees, was also present.

Dr. Fuller reported that the expenses of the commission for the current year to date had been \$190.

It was agreed that since Dr. William D. Stroud had been very active in heart work he should be requested to accept membership on the commission as an *ex officio* consultant.

Dr. Fuller suggested that a letter be addressed to the chairmen of county medical society Committees on Rheumatic Fever in order to revive interest in future programs on rheumatic fever in the county societies, and also to obtain a recheck on any changes of committee chairmen.

It was agreed that the scientific exhibit used last year should be revised and used in addition to a new exhibit to be prepared by Dr. Kitchell on the treatment of rheumatic fever with penicillin, sulfonamides, and some of the newer drugs such as ACTH.

SPECIAL NOTE: In a letter dated May 9, 1950, Dr. Fuller made the following proposal:

(1) That the commission through Dr. Kitchell be responsible for the preparation of an exhibit with emphasis on penicillin treatment in addition to using the exhibit prepared for the 1949 convention.

(2) That Dr. Ella Roberts of the Children's Heart House prepare an exhibit on the treatment of rheumatic fever by means of sulfa drugs.

(3) That the Pennsylvania Heart Association prepare an exhibit on general current pamphlets.

(4) That these three booths adjoin each other at the meeting of the State Society.

Mr. Richards stated that the total number of cases of rheumatic fever reported to date was 1058. The number of active cases was 557, inactive cases 460, and unclassified cases 41.

It was agreed that Dr. Faller should attend the meeting of the Pennsylvania Academy of General Practice to be held in Harrisburg on May 25 and attempt to stimulate interest in registering cases of rheumatic fever.

Mr. Richards reported that several requests for speakers at county medical society meetings had been received and that Dr. Cowley was making the necessary arrangements.

The report of the commission concerning Chapter M of the Public Health Survey report was returned by the Commission on Preventive Medicine and Public Health with the comment that it desired more specific data on the recommendations contained in the chapter. A revised report is therefore to be prepared.

It was decided that a meeting of the commission should be scheduled for some time during the annual state convention, Oct. 15-19, 1950, and that to this meeting should be invited the chairmen of the county Committees on Rheumatic Fever.

The meeting was adjourned at 12:45 p.m. to meet with representatives of the Pennsylvania Health Department and the Pennsylvania Heart Association.

Joint Meeting

A meeting of the Commission to Study Control of Rheumatic Fever of The Medical Society of the State

of Pennsylvania with the Committee on Rheumatic Fever of the Pennsylvania Heart Association and representatives of the Division of Rheumatic Fever Control of the State Health Department was held at 2 p.m., Monday, May 8, in the Penn-Harris Hotel, Harrisburg.

Present were: Drs. Andrew B. Fuller, Ralph L. Shanno, Allen W. Cowley, Constantine P. Faller, James R. Kitchell, Paul B. Kreitz, Thomas P. Tredway, Mary L. Richardson, Paul Dodds, and Ella Roberts.

Also present were Mr. Charles Mears, executive director of the Pennsylvania Heart Association, and Mr. Robert L. Richards, staff secretary to the committees of The Medical Society of the State of Pennsylvania.

Dr. Fuller stated that the meeting was called primarily to organize a coordinated program in the State for the control of rheumatic fever. He pointed out that the cancer agencies in the State have been able to coordinate their programs and that it might be expedient for the groups interested in rheumatic fever to establish a similar type of coordination.

Dr. Fuller stated that in general the functions of the three groups are as follows:

The Pennsylvania Heart Association is largely responsible for education and research.

The Commission to Study Control of Rheumatic Fever of The Medical Society of the State of Pennsylvania is largely responsible for regulation of physician activities with emphasis on education of the profession.

The Division of Rheumatic Fever Control of the State Health Department conducts the program of rheumatic fever control through the operation of diagnostic clinics and supervises their administration.

Dr. Fuller mentioned that the Clinic Crediting Committee of the Pennsylvania Heart Association, which will function as an approving agency for clinics to be established in hospitals, might prove to be a fourth group which should be represented in the total program.

Dr. Dodds suggested that each organization describe in detail its present functions and future planning in order that all may know what is being done and what is contemplated for the future.

Dr. Fuller accepted this suggestion and outlined the activities of the Commission to Study Control of Rheumatic Fever (Appendix A).

Dr. Kitchell reported that his Committee on Rheumatic Fever of the Pennsylvania Heart Association was meeting in the afternoon to outline its program and would submit a report to be appended to these minutes (Appendix B).

Dr. Richardson outlined the program of the Division of Rheumatic Fever Control of the State Health Department (Appendix C). He distributed illustrative material and described in detail its various uses. A copy of this material may be secured by writing directly to the Division of Rheumatic Fever Control.

Appointment of Coordinating Committee: Following appropriate discussion of each of the oral reports, it was the consensus that Dr. Fuller should appoint a committee with authority to meet and determine a program of coordination of the various activities. The hope was

expressed that this committee might meet this summer and make recommendations to a meeting of the three groups in the fall, at which time they might recommend a total program for the State in regard to rheumatic fever control.

Dr. Fuller appointed the following committee:

Dr. Paul V. Dodds, chairman pro tempore, and permanently ex officio.

Dr. Mary L. Richardson, representing the Division of Rheumatic Fever Control, State Health Department.

Drs. Ralph L. Shanno and Allen W. Cowley, representing the Commission to Study Control of Rheumatic Fever of The Medical Society of the State of Pennsylvania.

Drs. James R. Kitchell and Ella Roberts, representing the Committee on Rheumatic Fever of the Pennsylvania Heart Association.

Ex-officio members: Dr. Andrew B. Fuller, Mr. Charles Mears, and Mr. Robert L. Richards.

Use of Federal Funds: The subject of using Federal funds for rheumatic fever was discussed, and it was suggested that, if the Pennsylvania Heart Association wished to do so, it might make application for funds for establishing additional nursing services in certain counties as a test program.

Registration of Cases: The question was raised as to whether or not the registration of cases by the commission should be continued. It was generally agreed that such registration was valuable in order to ascertain a complete picture of the approximate number of cases of rheumatic fever in the State. It was suggested that possibly the limitation of reporting cases under the age of 21 should be removed in order that all cases would be included.

It was decided that Dr. Dodds, as chairman of the Coordinating Committee, should be responsible for calling the next meeting of the three groups after his committee has had an opportunity to review the total program.

The meeting was adjourned at 3:30 p.m.

Appendix A

Report on the History and Activities of the Commission to Study Control of Rheumatic Fever of The Medical Society of the State of Pennsylvania

The Commission to Study Control of Rheumatic Fever was established by the 1944 House of Delegates of The Medical Society of the State of Pennsylvania. Since that time, the commission has rendered annual reports to the House of Delegates which are available in the December issues of THE PENNSYLVANIA MEDICAL JOURNAL and may be reviewed at the headquarters building, 230 State St., Harrisburg, Pa.

The membership of the commission is appointed by the president of The Medical Society of the State of Pennsylvania. At the present time the commission has a limited budget of several hundred dollars per annum and meets approximately three or four times between sessions of the House of Delegates. Funds may be secured for special projects by submitting requests

directly to the Board of Trustees, which is the commission's governing body between sessions of the House of Delegates.

The commission is primarily interested in three projects: (1) education of the profession; (2) appointment and activation of committees on rheumatic fever in the sixty county medical societies; and (3) maintaining a file on cases of rheumatic fever in the State of Pennsylvania.

In its professional education program, the commission advocates and establishes postgraduate seminars throughout the State under the sponsorship of the Commission on Graduate Education of The Medical Society of the State of Pennsylvania. It also encourages programs in county medical societies and suggests to program chairmen that at least one program on rheumatic fever be conducted each year. Also, it is responsible for the preparation of a scientific exhibit at the annual convention of the State Society. The commission also promulgates the study of rheumatic fever through the Committee on Scientific Work of The Medical Society of the State of Pennsylvania and arranges seminars and speakers for the annual state conventions. This is usually accomplished at the request of the commission chairman.

In regard to the second project, the commission has requested the appointment of a Committee on Rheumatic Fever in each county medical society and has received the designation of a chairman from each of the county societies. From time to time, information is mailed to these chairmen so that they may disseminate it to their membership. A meeting of these chairmen is also called each year and is usually held during the annual convention, at which time mutual problems are discussed and the chairmen are familiarized with the program of the commission and encouraged to take an active part in its projects. They are also encouraged to support associated activities, such as the Pennsylvania Heart Association, and to cooperate with the State Health Department in the program of its Division of Rheumatic Fever Control. The commission encourages county medical society committee chairmen and members to speak before lay groups on the subject of rheumatic fever control. These programs are usually arranged at the local level and, therefore, a detailed report of the activities is not available. At the request of lay or professional groups the commission also furnishes speakers on the subject of rheumatic fever.

The third major project is of recent origin compared with the other two. However, the commission, through its efforts and those of county medical society chairmen, has been able to register 1060 cases of rheumatic fever under the age of 21 in a central file located at the headquarters building. It is anticipated that the age limit will be removed in the near future in order that *all* cases of rheumatic fever may be reported. It has been advised and agreed that the registration of these cases is a worth-while project and that the files should be retained at the State Society headquarters if at all possible. A detailed summary of these cases is not available, but it is expected that within the next several months such a report will be prepared, possibly to be presented in its report to the next meeting of the House of Delegates in October, 1950.

The commission has interested itself in establishing a Coordinating Committee which was appointed at its last meeting and it is the hope of the members that such a committee may be better able to cope with the problems of rheumatic fever through a more coordinated program of all agencies interested in the problem.

Respectfully submitted,

ANDREW B. FULLER, M.D., *Chairman.*

Appendix B

Report of the Rheumatic Fever Committee of the Pennsylvania Heart Association, Inc.

The Pennsylvania Heart Association, Inc., was organized as a direct affiliate of the American Heart Association in September, 1949. One functioning division of the state organization is the Rheumatic Fever Committee. This committee is made up of the following:

James R. Kitchell, M.D., Philadelphia, *chairman*
John P. Hubbard, M.D., Philadelphia
Ralph L. Shanno, M.D., Forty Fort
Ella Roberts, M.D., Philadelphia
Hubley R. Owen, M.D., Philadelphia
Theodore Elterich, M.D., Pittsburgh
Alfred W. Dubbs, M.D., Allentown

This committee exists for the purpose of studying the rheumatic fever problem in the State and recommending those measures which can effectively be carried out on a state level, and to offer suggestions to chapters so that they in turn may be instrumental in helping to develop comprehensive local rheumatic fever programs.

The above aim shall be accomplished by a close working relationship between the medical, public health, social welfare, rehabilitation, and educational authorities.

The interest of the Pennsylvania Heart Association and its chapters is in supporting a total rheumatic fever program which would: (1) find individuals with rheumatic fever; (2) remove the label of rheumatic fever from those falsely diagnosed; (3) promote the development and integration of services needed in the State and communities and insure that patients receive adequate and continuing care.

This over-all program should include such major activities as are centered in prevention, diagnosis, case finding, rehabilitation, and an educational program involving agency, professional, and lay education. The committee is also interested in considering heart disease control grant-in-aid funds, which might be used to advantage in supporting a total state program—this to be done in cooperation with other agencies.

Chapters of the Pennsylvania Heart Association can and are developing programs which apply to the rheumatic fever field.

Some groups are establishing case registers on a local level.

A number of chapters are already providing personnel to do follow-up work on the basis of referrals from hospitals, clinics, or private physicians.

Through the state association and its chapters, educational material is being provided to organizations, individuals, and schools.

A few chapters have arranged for educational meetings for professional personnel. This area of work can

best be accomplished by the state and county medical societies in cooperation with the Heart Association chapters.

In a few cases heart chapters provide certain limited medical services to indigent patients.

The state association and its chapters are interested in raising the level of service provided by clinics and convalescent facilities and through the American Heart Association provide means for clinics to be accredited.

As the state and community rheumatic fever programs become firmly established they may be extended gradually to care for individuals suffering from rheumatic heart disease in older age groups. We must of necessity consider this possibility in developing a total program.

Respectfully submitted,

JAMES R. KITCHELL, M.D., *Chairman.*

Appendix C

Report of Activities of Division of Rheumatic Fever Control, State Health Department

The Rheumatic Fever Division in the Bureau of Maternal and Child Health of the Pennsylvania Department of Health provides diagnostic and consultative service to the physicians and people of the State of Pennsylvania. This service is supplied by sixteen rheumatic fever clinics in as many cities of the State. These clinics are in addition to the ones operated by the cities of Pittsburgh and Philadelphia.

Each clinic is held in a hospital where there are facilities for any laboratory work indicated, where x-ray, fluoroscopy, and electrocardiographic studies may be made.

The personnel of each clinic includes the director—a physician certified in either pediatrics or internal medicine, a state public health nurse, and a secretary. No charge is made to any resident of Pennsylvania regardless of ability to pay. No patient is accepted beyond his 21st birthday.

Patients are seen only by appointment and that appointment must be requested by the family physician.

The service does not give therapy, but included in the report that is mailed to the referring physician immediately after examination of the patient are specific recommendations for the care of that particular patient and a suggestion for re-examination when indicated.

The service is concerned with the identification of hitherto undetected rheumatic fever and rheumatic heart disease with the evaluation of patients previously diagnosed.

Every effort is made within the means available to see that the child with rheumatic fever and rheumatic heart disease gets proper care.

Many non-rheumatic patients and patients with congenital anomalies are seen. A real service is rendered these patients by the clinics.

The first group has the stigma and fear of heart disease removed, and the second is referred to special clinics where, if indicated, cardiac surgery is available.

The rheumatic fever clinics have been established and maintained by the appropriation of Commonwealth funds. The State Medical Society approves and cooperates. In each community in which a clinic is estab-

lished the county medical society approves its establishment.

Patients are referred to the clinics in various ways, but are examined only on request of the family doctor. Most are referred directly by the family physician, but a third or more are referred because of findings in the routine school examination. Parents of these patients are contacted by form letter and told of the clinic service available upon written request by their family physician.

At regular intervals follow-up questionnaires are sent to these doctors asking for record of recurrence of rheumatic fever episode and a few other facts pertinent to the general condition of the patients. Approximately 60 per cent of those mailed less than a month ago have already been returned.

Respectfully submitted,

MARY L. RICHARDSON, M.D., *Director.*

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since April 24. Figures in first column denote county society numbers; second column, State Society numbers.

May 1	Dauphin	252	9500	\$23.00
	Wayne-Pike	25	9501	23.00
	Perry	10	9502	23.00
	Lycoming	125-127,		
		129-132	9503-9509	161.00
	Fayette	107	9510	23.00
	Lackawanna	258-260	9511-9513	69.00
	Chester	114	9514	23.00
	Montgomery	286-289,		
		302-310	9515-9527	299.00
	Beaver	126	9528	23.00
	Jefferson	55	9529	23.00
	Cambria	151-152	9530-9531	46.00
	Crawford	53-55	9532-9534	69.00
2	Bedford	9	9535	23.00
	Schuylkill	144, 146-150	9536-9541	138.00
3	Blair	113-114	9542-9543	46.00
	Venango	47	9544	23.00
5	Greene	23	9545	23.00
8	Philadelphia (1949)		10773	15.00
	Montgomery	311-313	9546-9548	69.00
	Bucks	82-83	9549-9550	46.00
	Delaware	287-289	9551-9553	69.00
	Lackawanna	261	9554	23.00
	Fayette	108	9555	23.00
10	Philadelphia	2608-2839	9556-9787	5,336.00
11	Westmoreland	201-204	9788-9791	92.00
	Jefferson	56	9792	23.00
	Fayette	109	9793	23.00
15	Blair	115	9794	23.00
	Butler	63		11.50
	Butler	64-65	9795-9796	46.00
	Venango	48	9797	23.00
	Lackawanna	262	9798	23.00
	Delaware	290-292	9799-9801	69.00
	Elk	25	9802	23.00

May 16	Mifflin	31-38	9803-9810	\$184.00
	Cambria	153	9811	23.00
	Luzerne	351-356	9812-9817	138.00
	Northampton	235	9818	23.00
	Lawrence	81	9819	23.00
19	Fayette	110	9820	23.00
	Columbia	45	9821	23.00
	Mercer	82	9822	23.00
	Bucks	84-85	9823-9824	46.00
22	Lackawanna	263	9825	23.00
	Erie	200	9826	23.00
	Blair	116	9827	23.00
	Northumberland	72-73	9828-9829	46.00
23	York	166	9830	23.00
24	Lancaster	224-225	9831-9832	46.00
25	Lancaster	226	9833	23.00
	Fayette	111	9834	23.00
	McKean	49	9835	23.00
	Luzerne	357-359	9836-9838	69.00
26	Berks	245-246	9839-9840	46.00
29	Lackawanna	264-265	9841-9842	46.00
	Montgomery	327-333	9843-9849	161.00
	Berks	247	9850	23.00
	Montgomery	314-326	9851-9863	299.00
	Lawrence	82	9864	23.00

CHANGES IN MEMBERSHIP

New (41) and Reinstated (5) Members

ALLEGHENY COUNTY: Kenneth I. Fetterhoff, Francis W. Joyce, Stephen R. Keister, Lyndon H. Landon, Jr., Donald H. Rice, Charles Spiegel, and Oliver T. Steen, Pittsburgh.

BERKS COUNTY: Thomas V. Bosch, Birdsboro; Cedric C. Jimerson, Reading.

BUCKS COUNTY: George W. Shaffer, Blooming Glen.

CAMBRIA COUNTY: (Reinstated) George Sahlaney, Johnstown.

DELAWARE COUNTY: John D. Hallahan, Media; Oscar K. Lanich, Jr., Ridley Park.

ERIE COUNTY: Edward B. Wells, Erie.

FAYETTE COUNTY: Daniel B. Glickman, Uniontown.

LANCASTER COUNTY: Charles G. Francos, Lancaster.

LAWRENCE COUNTY: John G. McConahy, III, and George Stitzinger, New Castle.

LUZERNE COUNTY: (R) Olive T. Baskett, Retreat.

MIFFLIN COUNTY: Dorn S. Hower and Frank R. Kinsey, Lewistown.

MONTGOMERY COUNTY: Charles Catanzaro, Norristown; Wallace L. Davidson, Douglassville; Alexander Randall, IV, Josephine P. Randall, and Roy A. Wenhold, Abington.

NORTHUMBERLAND COUNTY: Creighton L. Lytle, Sunbury.

PHILADELPHIA COUNTY: Howard E. Bricker, Chester; R. Dietz, William L. Drake, Jr., Paul R. Dumke,

James J. Fiedler, Frank A. Lippi, Francis J. Murphy, Albert Nemez, Leonard J. Raider, Howard D. Trimpi, George A. West, and Yasohichi Yoshida, Philadelphia; Herman G. De Cherney, Farnhurst, Del. (R) Thomas Kerr, Jr., Philadelphia; Morton M. Kligerman, New York, N. Y.

VENANGO COUNTY: Pauline W. McCandless, Franklin; Robert N. Ricketts, Oil City.

WESTMORELAND COUNTY: Alan W. Shriver, Greensburg. (R) Charles F. Fox, Vandergrift.

Resignations (22), Transfers (6), Deaths (17)

ALLEGHENY: *Resignations*—William D. Cleland, Jr., Detroit, Mich.; Walter F. Edmundson, John P. Griffith, Jr., and James E. Hayden, Washington, D. C.; Richard F. McClure and George H. Ward, San Francisco, Calif.; Herman Fischer and Vincent C. Scoglietti, Pittsburgh. *Deaths*—Christian Hager, Braddock (Univ. Munich, Germany, '84), May 16, aged 91; William P. McCorkle, Jr., Pittsburgh (Jeff. Med. Coll. '33), May 28, aged 43; I. Bebout Reed, Pittsburgh (Jeff. Med. Coll. '86), May 4, aged 87; Charles E. Ziegler, Miami Shores, Fla. (Univ. Pa. '00), April 28, aged 79.

BERKS: *Resignation*—Robert J. Saul, Reading.

ERIE: *Resignation*—Harold B. Lang and Kenneth L. Burt, Erie.

FAYETTE: *Death*—Lewis N. Reichard, Brownsville (Coll. Phys. & Surg., Baltimore, '09), May 17, aged 73.

JEFFERSON: *Death*—James C. Borland, Falls Creek (Jeff. Med. Coll. '05), February 4, aged 72.

LACKAWANNA: *Death*—Edward E. Edwards, Taylor (Univ. Louisville '09), April 15, aged 67.

LUZERNE: *Transfer*—Hugh J. Lenahan, Oakland, Calif., to California State Medical Society. *Deaths*—Maurice B. Ahlborn, Wilkes-Barre (Univ. Pa. '98), April 9, aged 73; Thomas F. Fleming, Exeter (Baltimore Med. Coll. '01), May 6, aged 75.

MONTGOMERY: *Resignation*—Lee F. Mauger, Pottstown. *Death*—Albert Garner, Norristown (Hahn. Med. Coll. '02), May 9, aged 73.

NORTHAMPTON: *Deaths*—Edward S. Rosenberry, Stone Church (Jeff. Med. Coll. '95), April 30, aged 83; Clayton P. Struthers, Raubsville (Med.-Chi. Coll. '16), April 16, aged 55.

PHILADELPHIA: *Transfers*—William R. Leute, Jr., Haverford, and Harold A. Taggart, Drexel Hill, from Delaware County Society; Horst A. Agerty, Philadelphia, from Montgomery County Society; John J. Kennedy, Cedar Brook, N. J., to New Jersey State Society; Howard Z. Fretz, Wharton, Tex., to Texas State Society. *Resignations*—Beatrice W. Connelly, Lillian E. Fredericks, Harry G. Merker, Jerome D. Valentine, Samuel Friedenber, Ernest A. Spiegel, John Wesley Thomas, Jr., and H. Stephen Gallagher, Philadelphia; Robert W. Kiley, Johnson City, N. Y.; Ralph M. Lindsey, Grand Rapids, Mich. *Deaths*—Cyrus Ward Fridy, Collegeville (Univ. Pa. '04), May 13, aged 72; Francis R. Packard, Philadelphia (Univ. Pa. '92), April 18, aged 80; Frederick A. Sutliff, Philadelphia

(Univ. Pa. '02), April 20, aged 77; Leo J. Wocjynski, Philadelphia (Jeff. Med. Coll. '11), April 18, aged 63.

WESTMORELAND: *Death*—Charles H. Marks, New Kensington (Hahn. Med. Coll. '23), May 14, aged 52.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Medical Society of the State of Pennsylvania	\$500.00
Woman's Auxiliary, Warren County	75.00
Woman's Auxiliary, Centre County	60.00
Woman's Auxiliary, Crawford County	50.00
Woman's Auxiliary, Carbon County	57.00
Woman's Auxiliary, Blair County	50.00
Woman's Auxiliary, Erie County	250.00
Woman's Auxiliary, Beaver County in memory of Mrs. J. R. Gormley	10.00
Woman's Auxiliary, Northampton County ...	300.00
Woman's Auxiliary, Huntingdon County	50.00
Woman's Auxiliary, Montgomery County	650.00
Woman's Auxiliary, Mercer County	165.00
Woman's Auxiliary, York County	100.00
Woman's Auxiliary, Lebanon County, a friend in memory of Tom K. Smith	5.00
Woman's Auxiliary, Montgomery County	120.55
Woman's Auxiliary, Montgomery County, a friend in memory of Mrs. Lyda Helsel	5.00
Woman's Auxiliary, Somerset County	60.00
Woman's Auxiliary, Clinton County	75.00
Woman's Auxiliary, Chester County	150.00
Woman's Auxiliary, Indiana County	110.00
Woman's Auxiliary, Luzerne County	225.00
in memory of Dr. Stanley Freeman	30.00
Woman's Auxiliary, Washington County	125.00
Previously reported	5,621.22

Total contributions since 1949 report\$8,843.77

MAKING HEALTH VISIBLE

The Medical Society of the State of Pennsylvania maintains a library of 16 mm. sound films on health subjects suitable for lay audiences which are available, on loan, to county medical societies, individual physicians, hospitals, service and women's clubs, schools, and other groups. There is no charge for these films other than the cost of return postage and insurance. Requests for films should be addressed to the Committee on Public Relations, The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa. Catalogs will be sent on request.

Twenty-three films, loaned by the Film Library, were

used in 53 showings during the month of May. They were:

A Criminal Is Born

Psychology classes, Thompson Business College, Harrisburg
High school sociology classes, Lewistown
Sportsman Association, Halifax
Adult group, Steelton
Mt. Pocono School

Be Your Age

High school health classes, Lewistown

Boy in Court

High school sociology classes, Lewistown
Sportsman Association, Halifax

Breast Cancer—The Problem of Early Diagnosis

Adams County Medical Society, Gettysburg
Schuylkill County Medical Society, Shenandoah

Defense Against Invasion

Girl Scouts, Middletown
Dauphin County poster contest judging, Harrisburg

Feeling of Rejection

Psychology classes, Thompson Business College, Harrisburg
Raub School PTA, Allentown
Junior-senior high school health classes, Palmerton

First Aid

Mt. Pocono School

Human Growth

Straws Consolidated School PTA, Fishing Creek Valley
PTA, Waterford High School
Grades 5 to 12, Waterford School
Youth Fellowships, Calvary Evangelical & Reformed Church,
Reading
Mothers' Club, Susquehanna Township School

Human Heart

High school health classes, Lewistown

Man's Greatest Friend

Daughters of American Revolution, Butler
YWCA, Butler (3 showings)
Student nurses, Butler County Medical Society, Butler

Men of Medicine

Lions Club, Pine Grove

Modern Guide to Health

Roosevelt School, Large
Jefferson Township schools, Large
Dauphin County poster contest judging, Harrisburg

New Frontiers of Medicine

Mt. Pocono School

One Against the World

Mt. Pocono School

Story of Dr. Jenner

Mt. Pocono School

Story of Menstruation

Girls' health classes, Hummelstown
Girl Scouts, Middletown

They Live Again

Daughters of American Revolution, Butler
YWCA, Butler (3 showings)
Student nurses, Butler County Medical Society, Butler

Traitor Within

Olmsted Air Force Base (7 showings)

Tuberculosis

Mt. Pocono School

Vim, Vigor, and Vitamins

Mt. Pocono School

What Is Cancer?

School of Nursing, State Hospital, Scranton

Your Ears

High School, Palmerton

Your Eyes

High School, Palmerton

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Do you have any puzzling diagnostic problems to solve or a paper to prepare for professional or lay audiences? If so, why not take advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania?

The library consists of a collection of more than 105,000 reprints and tear sheets from various publications which are filed for your use. Requests for material should be addressed to the Librarian, 230 State St., Harrisburg, Pa., and a package will be mailed to you for a loan period of two weeks. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material.

The following requests were filled during the month of May:

The heart in myxedema
Head injuries
Adaptation syndrome
Indolin in arthritis
Liver function tests
Mycosis fungoides
Chorea
Petit mal epilepsies
Allergic arthritis
Trichiniasis
Ulcerative colitis
Terminal ileitis
Dermoids of the ovary
Cancer
Pheochromocytoma
Breast feeding
Non-tropical sprue

Hypnotherapy
Beryllium poisoning
Chlorophyll
Male hormone therapy
Oxyuriasis
Hodgkin's disease
Myocardial infarction
Cancer cures
Hyperparathyroidism
Interventricular septum
Milk allergy
Bronchostenosis
Veterans Administration
Purpura
Treatment of clubfoot
Climate and disease
Effects of temperature

Studies of urobilinogen
Punch drunk
Tuberculous uveitis
Sprue
Myanesis
Treatment of poisoning
Penicillin sensitivity
Tumors of the neck
Precancerous and cancerous lesions of the skin
New drugs in ophthalmology
Etiology of the common cold
Auto-intoxication and arthritis
Fibrous dysplasia of bone
Atomic emergency disaster
Use of magnesium gluconate in dysmenorrhea
Waterhouse-Friderichsen syndrome
Anomalies of the hyoid bone
Arthritis and related conditions
Socialized medicine (2)
Use of antibiotics in brucellosis
Susceptibility of antibiotics
Oral treatment with vitamin B₁₂
Pulmonary function studies in asthma
Shock therapy in psychotic patients
Read's childbirth without fear
Treatment of neurosyphilis
Hodgkin's disease of the stomach
Carcinoma of the stomach
Chloromycetin in treatment of typhoid fever
Thrombophlebitis
Use of radioactive isotopes
Gastro-intestinal allergy
Endocrine disorders and the eye
Nursing homes in Pennsylvania
Drugs used in the treatment of obesity
Post-cholecystectomy syndrome and dystonia of the gallbladder *
Tattoo marks and their removal
Resistance to antibiotics
Medical schools in the United States

BRITAIN HAS NEW PROBLEM PLUS MORE EXPENSE

Britain's latest problem, ironic as it seems, is one of large stocks of food—enough, in fact, to permit increases in the people's rations. But, says a *New York Times* dispatch quoted in the *Wall Street Journal*, "this pleasant development puts the government in a 'peculiar situation.'"

In Britain, all foods are supported by heavy government subsidies. This makes it quite necessary for Sir Stafford Cripps, the budget manager, to consider seriously if the government can afford to let the nation eat more. He says the treasury can't permit that.

The *Wall Street Journal* suggests this alternative:

"The government could just put the extra food in the open market and let folks decide for themselves

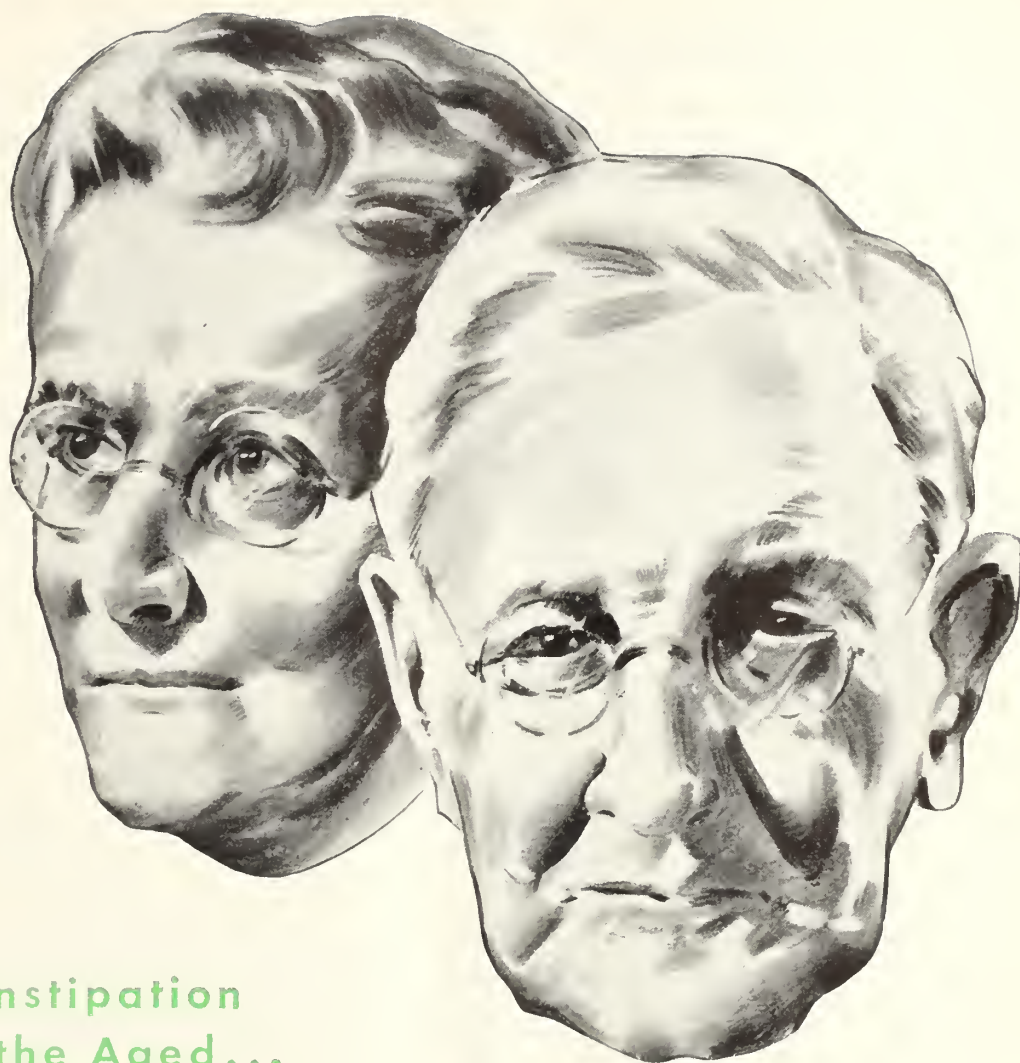
whether they wanted to pay more to eat more. That's a course the government is 'very reluctant to take'; things like that must be planned, not left to the people."

The editorial goes on to explain that the subsidy program was begun in the first place to help the people get food during a period of shortages. Going on, it comments:

"Now the shortages of most foods are ended. Yet the government cannot let the people have a better diet because of that self-same rationing and subsidy program.

"So because the government is so solicitous of the people's welfare the people can't have any more to eat.

"Have you ever noticed how planners do wonderfully well at planning austerity and find nothing so disconcerting as the least hint of abundance?"—*Minnesota Medicine*, May, 1950.



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PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Course Available

During the coming school year, the University of Pennsylvania will conduct three courses in the diagnosis and treatment of cancer.

The Cancer Control Division of the Pennsylvania Department of Health will pay the tuition of each registrant and will provide \$200 for living expenses.

Each course will be two weeks long and will consist of lectures, panel discussions, and clinical demonstrations. Four evening lectures will be given by outstanding authorities in the field of cancer in various parts of the country.

The dates for the courses are: October 23 to November 4, 1950; January 22 to February 3, 1951; and April 9 to 21, 1951. Each class is limited to 15 and application blanks may be secured by writing to the secretary of the Cancer Commission of the University of Pennsylvania, Hospital of the University, 3400 Spruce Street, Philadelphia.

New Film Available

Rehabilitation of laryngectomized patients is the subject treated in the film "We Speak Again" which was sponsored jointly by the Massachusetts Eye and Ear Infirmary, the American Cancer Society, and the society's Massachusetts Division.

"We Speak Again" opens with animated sequences describing a laryngectomy. The film follows a patient from the time when he is told of an impending operation until he is able to resume normal life through the use of his esophagus to produce the necessary sound for articulation by his speech organs. The patient is shown during the period of his instruction when his ability to vocalize progresses from painfully uncontrolled monosyllables to clearly delivered sentences.

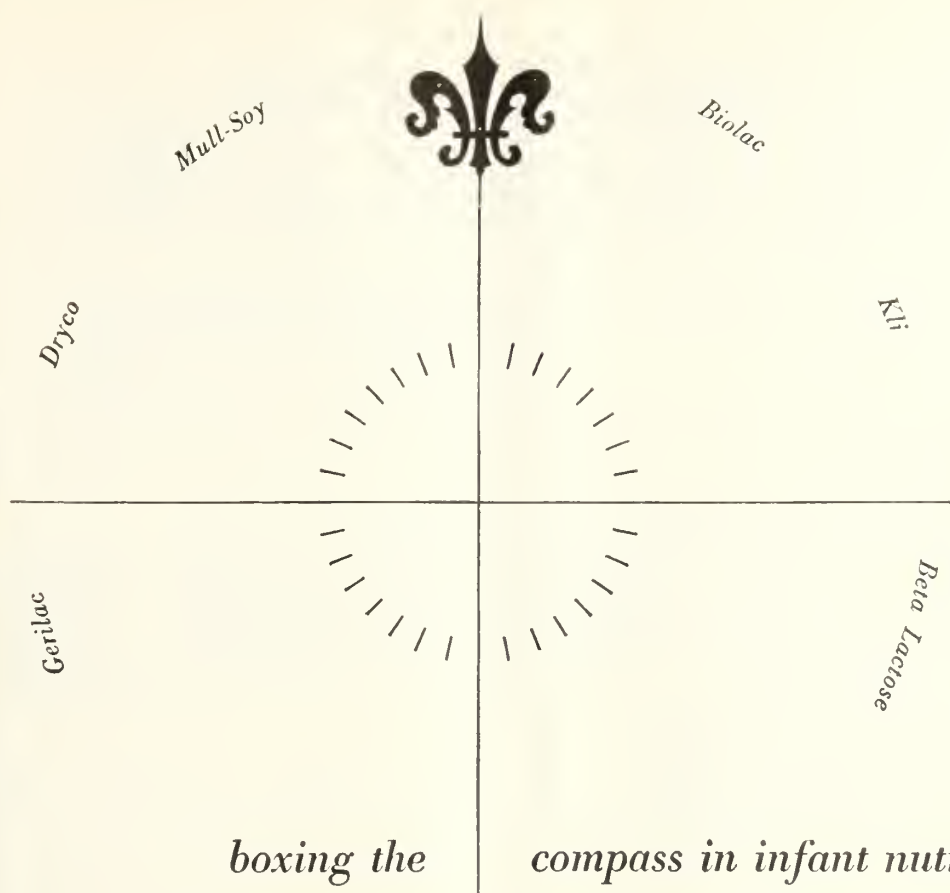
The patience of the teacher, who had herself undergone a laryngectomy and experienced rehabilitation through esophageal speech, is matched by the determination of her student to restore his powers of communication. The film projects the perseverance and courage of both teacher and student through the long process of re-education.

Prepared primarily for professional audiences, "We Speak Again" is suitable for showing to state and county medical societies, hospitals, public health staffs, schools of nursing, and medical and nursing conventions. Its running time is ten minutes. It is available for loan or purchase from Sturgis-Grant Productions, Inc., 314 East 46th St., New York 17, N. Y. The print cost is \$80. Rental fee is \$7.50.

Package Library

The Medical and Scientific Library of the American Cancer Society has established a package lending library of reprints on cancer covering the majority of articles published in the past ten years. The service is available through the Pennsylvania Division Office, Hall Building, Harrisburg, to doctors and research workers requesting it.

Because of the volume of material, only specific requests will be honored. Reprints must be returned within ten days.



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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

THE practicing physician and the public health worker are well aware that the magnitude of the chronic disease problem has been increasing. For this reason a practical procedure for screening out early cases of diabetes, cancer, tuberculosis, and syphilis and bringing them to the attention of the physician is very important.

THE CONCEPT OF MULTIPHASIC SCREENING

As tests for specific diseases have been perfected, methods have been developed for applying these tests on a mass basis. The chest x-ray for tuberculosis and the serologic test for syphilis are examples of tests suitable for mass application. Recently quick and economical methods of testing for blood sugar have been worked out. The determination of hemoglobin levels, vision, and hearing testing done routinely as in school examinations, and the taking of blood pressures, are simple procedures in common practice.

Until recently mass testing of the population,

using the tests and procedures mentioned above, has been limited. There have been separate mass surveys for tuberculosis, for syphilis, and for nutritional deficiencies. It is perfectly logical now for public health administrators to ask the question, "Why not combine as many of these tests as practical into a battery of tests, reduce the over-all cost of administering them, and thereby encourage universal usage?"

The Concept of Multiphasic Screening, A. L. Chapman, M.D., Public Health Reports, October 21, 1949.

MULTIPHASIC SCREENING EXAMINATIONS AN EXTENSION OF THE MASS SCREENING TECHNIQUE

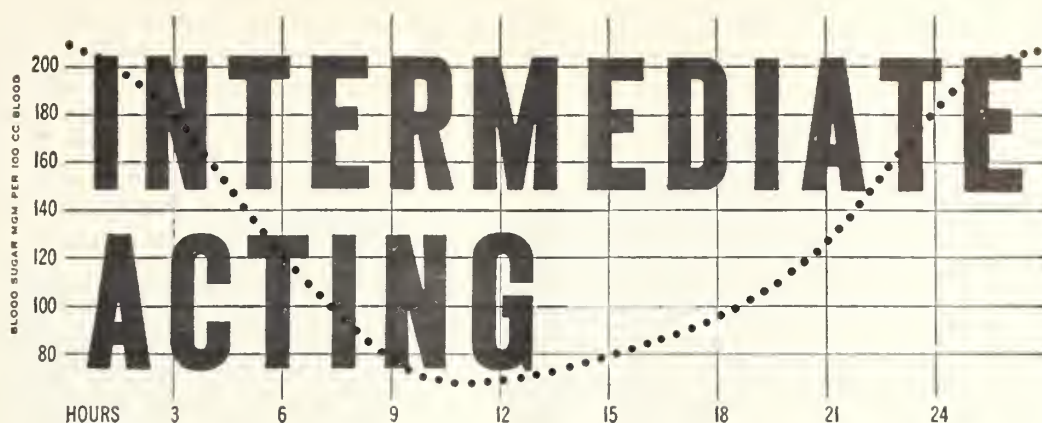
Public health workers are now directing their efforts to the control of the chronic diseases. Emphasis is correctly placed on prevention in chronic disease control in all fields of public health endeavor. The technique here presented is based on a fundamental concept in preventive medicine, the concept that early detection, early diagnosis, and adequate treatment can accomplish substantial reduction in disability and deaths from chronic disease.

This concept of preventive medicine is, of course, the basis for "periodic health examinations" which have been promoted during the past quarter of a century. These examinations for the early detection of disease are relatively expensive in terms of a physician's time and laboratory

services. Viewed as a technique for chronic disease control, they have severe limitations.

A different approach to the detection of disease in its early stages has long been known to public health agencies. Mass chest x-ray surveys using photofluorographic equipment and mass serologic testing programs for the detection of syphilis are well-established methods. Recently, comparable screening techniques have been developed for early detection of diabetes, certain types of heart disease, and cancers of certain sites.

These screening procedures are capable of wide application; they are relatively inexpensive per person tested; and they require relatively little time on the part of the physicians.



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1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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They have been used, for the most part, in separate case-finding programs. A population group in one city is screened for tuberculosis. In another, a group is screened for diabetes and, in still another, for syphilis. The question then arose—When we screen a population group for tuberculosis, why not also screen for syphilis, diabetes, heart disease, and cancer at the same time? The advantages of combined screening operations through a multiphasic screening procedure then become quite obvious.

For the individual who is served and for the administrative agency, it has many advantages. The discovery of active tuberculosis and early syphilis will vary with the type of population screened. However, for the adult population of the United States, the discovery rate of each of these diseases would probably be not less than 3 per 1000. In the case of diabetes, studies have indicated that approximately 7 previously unknown cases per 1000 persons tested would be discovered through blood-sugar and urine-sugar screening devices. A careful follow-up of persons whose miniature chest x-ray films disclosed abnormal cardiac shadows revealed that 10 per 1000 of the group studied had previously unknown, clinically significant heart disease.

By combining tests for these several diseases, one would expect to find, in a multiple screening of 1000 persons, approximately 20 to 30 persons with disease requiring the attention of a physician. Other tests such as hemoglobin determination, albumin test of the urine, blood pressure, weight, vision, and audiometric testing might well be incorporated into the battery. The screening procedures in all of these tests can be carried out by technicians. A physician is required only for rapid interpretation of certain test results and thereafter when there appears to be some lead which justifies a diagnostic study of the patient.

In San Jose, California, after extensive joint planning by a number of agencies, a multiphasic screening program was conducted on a trial basis last year. The County Medical Society, City Health Department, and State Department of Public Health carried out a survey covering 945

employees in four establishments. The screening procedures included a miniature x-ray film of the chest, test of the urine for albumin and glycosuria, a serologic test for syphilis, and the determination of blood-sugar level. A brief history form was used, with questions relating to heart disease, tuberculosis, diabetes, and syphilis.

About 15 minutes was required for each person tested. Although follow-up was deficient in certain respects, 13 cases of previously unknown significant disease were discovered and placed in the hands of physicians for care. These were cases of diabetes, active tuberculosis, and cardiovascular renal disease. Sixteen other cases of disease—previously known—were also disclosed.

Numerous problems in connection with multiphasic screening procedures have yet to be solved. These problems lie in the fields of technical development, professional education, professional relationships, and administration.

One problem is that of professional relationships. It should be emphasized that the multiphasic examination is a screening procedure, and is to be sharply differentiated from diagnosis. Screening represents a lead to diagnosis, and it is only that. Further definitive studies are needed and should be carried out where the patient is to receive his medical care. It may be desirable to repeat certain of the tests before the individual is referred for what may be an expensive diagnostic study.

The multiphasic screening procedure is not a substitute for a visit to a physician. Annual visits to a physician, whether symptoms are present or not, are obviously desirable.

The multiphasic screening procedure, through which 20 to 30 cases of significant disease may be discovered per 1000 persons tested, constitutes a practical approach to the present-day problems in preventive medicine. This preventive technique—designed for the early detection of groups of these diseases—merits further consideration, study, and exploration.

Multiphasic Screening Examination, Lester Breslow, M.D., American Journal of Public Health, March, 1950.



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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

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OPPORTUNITY TIME



Summertime is vacation time, and to all intents and purposes county auxiliaries have by this time "closed up shop" for the summer months. Meetings of a formal nature are over and members have scattered to vacation spots for rest and relaxation.

County presidents have recounted their year's work in final reports and the new presidents are planning for their term of office.

However much we should like to forget work of all kinds, it is not possible to close our minds completely to auxiliary responsibilities. "Auxiliary" is a continuous process and the activities of one term of office closely overlap and merge into the next. We are like a huge power machine whose force comes from many wheels within wheels, the cogs of one fitting perfectly into the cogs of another so that each turns in proper rhythm. Your state president with her officers and chairmen of the state board are still in office, for various phases of the state work continue over the summer, although the county presidents who served with her have now turned their files over to their successors. Your state president-elect has already contacted those who will serve with her, so that when the annual meeting takes place in October, the turning of the wheels will continue as smoothly as though no change in power had taken place. This is as it should be—no interruption of the current which provides the energy to keep auxiliary wheels constantly in motion.

And so, over the summer, each individual member continues this process at local levels, no matter where she may be, through that ever-present auxiliary function called public relations. It is, fortunately, just as potent at seashore and mountain resort as it is at home. The opportunity to expand and increase that potency presents itself as we meet new friends, make new acquaintances, and particularly as we meet, perhaps, the families of physicians from other states

and communities. It was a unique experience last summer for your president to be able to tell the story of the work of Pennsylvania's Auxiliary to three physicians and their wives. Their amazement at the potential force and influence of doctors' wives as auxiliary members, in groups or as individuals, knew no bounds. They went home laden with literature, including information concerning the need for their assistance in the National Education Campaign, and a determination to see what was being done in their communities, especially by their local medical societies and auxiliaries. I cannot help but feel that the interest created there has spread from those three families to others in their home towns.

In an address before the National Education Campaign Committee of the AMA, Miss Leone Baxter made the following statement: "I think it will be significant to you to know that in the endorsement drive some of the best work has been done by the states where the closest liaison exists between the auxiliary and the medical society. As a matter of fact, the states turning in the best total effort in the campaign are those in which the auxiliaries have worked closely on the four activities on which the National Committee had asked them to be active—literature distribution, women's page publicity, endorsements, and speaking. Today, however, our mail from some auxiliary members throughout the country indicates some needs that I should like to mention. The state auxiliary leaders are sent all the campaign material, including the policy decisions from the national office. But it appears that they need more policy direction—more information from their own state societies concerning the local campaign pattern—than they are getting now. In the campaign work, frankly, it appears that they need in many cases to be taken somewhat more into the confidence and into the conferences of their own state societies."

The above quotation has no application to The Medical Society of the State of Pennsylvania and its relationship to the State Auxiliary. No auxiliary could ask for more cooperation and



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assistance than that extended to us by our state officers—but, if you substitute the word “county” for the word “state” every time it is used in Miss Baxter’s address, you have a picture which is very true of Pennsylvania at the county level in many areas. How much more effective and efficient the Education Campaign could be in Pennsylvania if *all county medical societies* would express confidence in the *county auxiliaries* and would make full use of the energy, talent, and ability waiting there to be of service. A tremendous *force* to assist in medicine’s fight against government control of the profession lies seemingly unwanted and unrecognized in counties where the auxiliaries have not been asked to assist in the Education Campaign (and, unfortunately, in a few instances, have been refused permission to be active participants). However, auxiliary members can always be active as individuals, summer or winter, on vacation or at home, and their training as good public relations agents has been at work in the clubs and groups in which almost every woman has a part these days.

Since obtaining endorsements is the main issue of the National Education Campaign now, every one of the auxiliaries to the county medical societies in the State stands ready to serve. The *force* of almost 5000 members can bring in many more than the desired 1000 resolutions if the societies really want the job done and show the auxiliaries that they have confidence in their ability to be of service by giving them the green light and the go-ahead signal. The summer months provide an excellent time to prepare for contacting clubs and groups as soon as they resume activities in the fall months. Some of the “Who, What, When, How, Where, and Why” facts about resolutions and the endorsement drive are listed as thought-provokers on this vital issue:

WHO—can get a resolution? **YOU**, if you belong to any club or organization from the smallest church guild to the largest civic enterprise.

WHAT—is a resolution? A written expression of opinion of a group or organization which has been informed on an issue and is willing to write and talk to congressmen in an effort to back up their stand.

WHEN—do we get resolutions? As soon as possible. Summer months provide the oppor-

tunity to offer speakers to groups for early meetings when activities begin in the fall. Will you approach the program chairman of *your group or club now?*

HOW—do auxiliary members secure resolutions?

1. Clear with your local medical society first about participation in the drive. You should have no trouble convincing them that you can do a good job.
2. Organize your county campaign along lines suggested by the blue pamphlet, "What About Endorsements," which your county president received in May, as suggested by the State Public Relations Committee.
3. Check the resolutions already on record—then list the organizations not on record, and go after them.
4. Suggested resolutions are available from "230 State Street, Harrisburg." Be sure that copies go to the Senators and Representatives *and* two copies to the Harrisburg office of The Medical Society of the State of Pennsylvania.

WHERE—do we secure resolutions? From any organized group of people, in every hamlet, town, and city in the Commonwealth. No organization should be overlooked—every organization is a potential ally. The Auxiliary should concentrate especially on securing support from women's organizations or those composed largely of women.

In the words of the AMA president, Dr. Elmer Henderson, "Every time a resolution is read aloud before any group, whether of a dozen or a thousand members, another chain reaction is set off to help the cause. Arguments and opinions stated in the resolution itself serve this purpose. It is therefore worth while to have a resolution read for consideration, even in circumstances when no vote is expected . . ."

WHY—do we secure resolutions? To quote Miss Baxter again, "Because on a political issue, a righteous cause and pure hearts aren't enough. It takes strong allies as well, and many of them. It takes great multitudes of voices to be heard plainly in Washington."

The resolutions we secure will be the voices which Washington will hear speaking for the cause of a *free America*.

The Education Campaign is the business of every member of a county medical society and of



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his wife who is an auxiliary member. During the summer you can be a big I.A.M.—the Individual Auxiliary Member who never lets an opportunity pass to speak a word which may lead to the passage of another resolution.

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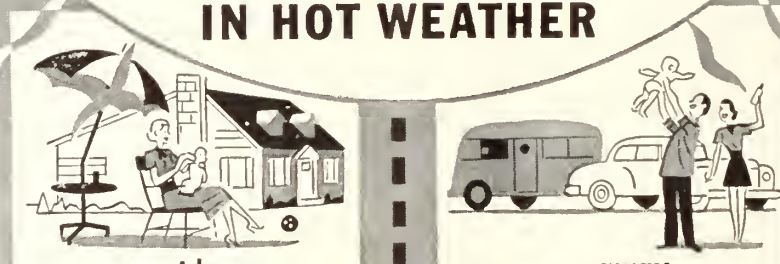
COMPULSORY HEALTH INSURANCE FOR AMERICA? NO!

BY GLADYS HALL SHAFER

Pennsylvania nurses must "wear three faces" when they weigh the promises made by advocates of a government-controlled compulsory health insurance system for general medical care against the accomplishments and potentialities of the present system of private medical and nursing services. The issue to be decided in

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Mrs. Shafer is chairman of the Public Relations Committee of the State Auxiliary.



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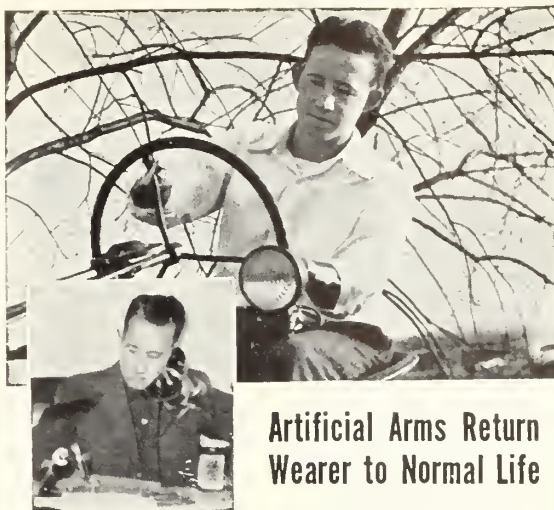
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Congress will affect each nurse in three ways: as a thinking citizen concerned with America's future, as a family member anxious to obtain the best medical care possible for loved ones, and as a member of a humanitarian profession aware of the complexities of health problems and the need for progressive improvement in health and welfare matters.

In this brief article I can only touch on subjects that deserve real study, point out the progress of health in America, raise the question of how far government responsibility should replace individual responsibility for those financially able to provide for themselves, and challenge the profession to oppose compulsory schemes leading to government control of medical and nursing care and to cooperate with others to improve the standards of health and distribution of services through means and methods that will not interfere with sound practices and basic freedoms.

S. 5, the 1949 reincarnation of the Wagner-Murray-Dingell bills, reappears as Section 7 of Senate Bill 1679, commonly termed the "Omnibus Health Bill." Cushioned by six other health measures (available in separate bills),¹



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Section 7 would saddle the nation with a compulsory health insurance scheme.

Medical progress, aided by better food, housing, and sanitation, has added 18 years to the lives of Americans born since 1900—the greatest advance in any comparable nation. (Even the Swedes live longer in Minnesota than they do in Sweden!) Latest available comparative statistics from the Public Health Service on the tuberculosis rate reveal 47 per 100,000 in the United States; 62 in England and Wales; 137 in France; and 160 in Russia. Yet all these nations except the United States have tax-supported and government-controlled medical care programs. America leads in the number of hospital beds and physicians per population and has, without question, the best medical education in the world. The same holds true for the nursing profession! In 1930, 56 children per 100,000 population between the ages of 5 and 14 died from tuberculosis, appendicitis, and heart disease; in 1946 only 16. Remember, the task of physicians and nurses is to reduce the death rate at each age, not to reduce the total number in an aging population. The oft-quoted arguments about preventable deaths used by Mr. Oscar Ewing are false, misleading, and cruel.²

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Traditional concern in America for the underprivileged has produced voluntary hospitals, free and part-pay clinics and services, and numerous health and charitable organizations. Government funds to supplement local resources when the need is proven have been used under proper safeguards successfully. The U. S. Public Health Service joins state and local health departments in the fields of prevention, sanitation, and education applicable to mass control. The Hill-Burton Act is already aiding 768 projects as of September, 1949, and offers supplemental funds to less favored areas for hospitals and diagnostic centers if local communities care

enough to do their share. If available resources and existing laws were utilized to their fullest extent and people educated to value health, further tremendous advances in medical care would be seen.

The Brookings Institution report notes that American families choose to spend 96 per cent of their incomes for services other than health needs and states that "the large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority in their budgets."³ For those with border-line incomes or dependent on the state, lack of money is a factor. However, we are already committed and obligated to provide these groups with their medical needs and can do a better job, if we care enough, without making all citizens dependent on the government. To ease the financial shock of unexpected and serious sickness, approximately 60 million Americans have voluntarily taken out some form of insurance coverage—either service types offered by Blue Shield and Blue Cross or refund types through reputable commercial concerns. Certainly, a majority of families can afford an item in their budget for serious illness equivalent to the price of a pack of cigarettes per day. If not,

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GYNECOLOGY—Intensive Course, two weeks, starting September 25. Vaginal Approach to Pelvic Surgery, one week, starting September 18.

OBSTETRICS—Intensive Course, two weeks, starting September 11.

MEDICINE—Intensive General Course, two weeks, starting October 2. Gastro-enterology, two weeks, starting October 16. Gastroscopy, two weeks, starting July 17, September 25.

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then how can they afford a deduction from pay envelopes to permit Washington bureaucrats to operate a plan for them?

The total cost to the taxpayers for a governmental compulsory and managed system of medical care is blissfully ignored by its advocates. The direct or wage tax is bound to be but a small part of the total cost, as has been discovered in England, where more than five-sixths of the cost is taken from general revenue and United States aid. Estimates by impartial actuaries place the cost for such services in the United States between 10 and 15 billion dollars per year. The total income of the federal government from all sources in 1941 was but 7.2 billions. Today our national budget is over 42 billions, six more billions than income. Maybe we should give a thought to our social morality to be sure we older people are not exploiting America's youth with our cradle-to-the-grave schemes. One might even be old-fashioned enough to ask, "Can we afford to buy a pig in a poke?"

What would happen to the quality of care under a compulsory health insurance system with nurses and doctors necessarily under government direction and regimentation? The Brookings

report states: "A real danger exists that government actions would impair the quality of medical care." Patrick Henry stated: "I have but one lamp by which my feet are guided, and that is the lamp of experience. I know of but one way of judging the future and that is by the past." Study for yourselves the quality of medical services given in fields where government has had control for years—in mental institutions, on Indian reservations, in veterans hospitals—until General Hawley demanded the right to weed out incompetents and to utilize local professional skills. Read the Hoover Commission report⁴ and see for yourself the waste, inefficiency, and overlapping of present government medical services and ask yourself, "Do I want to trust the same bureaucrats with more and greater responsibilities?" Dr. Ralph Gampell of England⁵ says, "Many people in England think the system is wonderful, for they prefer cough medicine to a proper examination." What Britain needed was more medical care; what she has done is to spread her services so thin that the care now given is inadequate and substandard for almost everybody. Dr. Frank Lahey of Boston⁶ states: "I have seen medicine dominated

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by government bring about deterioration in every country in which it has been undertaken." Dr. Andrew C. Ivy of Chicago says, "Under compulsory insurance systems people become numbers rather than individuals. This leads to a particular disregard of the underprivileged patient."

What about the "third face" as a member of the nursing profession? Senate Bill S-1679 promises "nursing care of the sick in the home by a registered professional nurse or a qualified practical nurse." A compulsory health insurance system—called by any name you please—can lead only to one thing—eventual control of services it promises in order to deliver the goods! Only a few words in the bill refer to nursing services, but many pages are devoted to it in what I call the "blueprint" of Social Security's Medical Care Plan.⁷ Certainly the whole issue is a direct challenge to the nursing profession to formulate its own beliefs and principles by which to judge all health and welfare legislation, to study the policies that guide the allied professions in evaluating proposed laws, and to heed the warning of Hon. James F. Byrnes when he said at Washington and Lee University: "Some of the new programs seriously proposed . . . would curtail the liberties of the people but are

offered in the name of public welfare and are to be made possible by federal aid. That phrase is an opiate. It is deceptive. The truth is there are no federal funds except those taken from your pockets. Beware of those who promise you something which does not belong to them and which can be given to you only at your own expense or the expense of another who may not produce to make the promise good."

REFERENCES

1. Senate Bill S. 1679 (H. R. 4312, 4313) composed as follows: Title 1 of S. 1453; 2 of H. R. 3942; 3 of H. R. 4215 and S. 614; 4 of S. 5, Sec. 256; 5 of S. 5 and S. 522; 6 of S. 904.
2. "The Nation's Health—A Report to the President" by Oscar R. Ewing, Social Service Administrator, 1948, U. S. Printing Office.
3. "The Issue of Compulsory Health Insurance," The Brookings Institution, 1948.
4. "Hoover Commission Report on Organization of the Executive Branch of the Government."
5. *Pennsylvania Medical Journal*, December, 1949.
6. *Lahey Clinic Bulletin*, January, 1948.
7. "Medical Care Insurance—A Social Insurance Program for Personal Health Services," Senate Committee Print No. 5, 79th Congress, 2nd Session. U. S. Printing Office, 1946.

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From the results it is apparent that the Administration's propaganda efforts in behalf of compulsory health insurance have made no advance in the past three years. Nevertheless, from a political point of view the fight is as hot as ever, for Mr. Ewing and his cohorts are still working with a high pressure of activity. The challenge must continue to be met by the group effort of the physicians of America, working in behalf of the public interest. In this the American Medical Association's National Education Campaign is the greatest single force.—*Connecticut State Medical Journal*.



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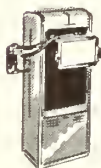
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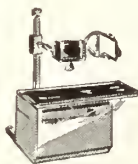
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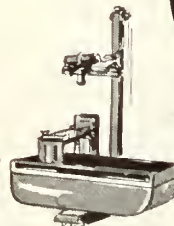
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MEDICAL NEWS

Births

TO DR. AND MRS. PETER L. BONAFEDE, of Harrisburg, a son, June 10.

TO DR. AND MRS. JAMES A. DICKSON, of Chambersburg, a daughter, June 12.

TO DR. AND MRS. THOMAS M. McMILLAN, 3d, of Bryn Mawr, a daughter, Katherine Hopkins McMillan, June 1.

Engagements

MISS ELINOR SYBIL KATZMAN, of New York City, to Joseph Medoff, M.D., of Philadelphia.

MISS EVELYN BAERINGER to Mr. Robert D. Kutteroff, son of Dr. and Mrs. Charles F. Kutteroff, all of Philadelphia.

MISS ALICE AMELIA FAY, daughter of Dr. and Mrs. Temple Fay, to Mr. Robert Clarence A. Hutton, all of Philadelphia.

MISS BARBARA ANNE VOEGELIN, daughter of Dr. and Mrs. Adrian W. Voegelin, to Mr. Matthias G. Lukens, all of Philadelphia.

MISS JANE DUNDAS FAY, daughter of Dr. and Mrs. Temple Fay, of Philadelphia, to Lt. (j.g.) Quinley Robert Schulz, USN.

MISS SYLVIA NANCY JAFFE, of New York, to B. Milton Garfinkle, Jr., M.D., son of Dr. and Mrs. B. Milton Garfinkle, of Harrisburg.

MISS PAULINE BEIN REIMANN, daughter of Dr. and Mrs. Stanley P. Reimann, of Philadelphia, to Mr. George Young Nehrbas, of Bryn Mawr.

MISS EDITH KINLOCH, daughter of Dr. and Mrs. Henry S. Kinloch, of Radnor, to Mr. James M. Hykes, son of Dr. James I. Hykes, of Haverford.

MISS ELIZABETH CORKRAN SKILLERN, daughter of Dr. and Mrs. Samuel R. Skillern, Jr., of Cynwyd, to Mr. Jonathan K. Miller, Jr., of Lansdowne.

MISS JEAN ELIZABETH SAFRIN, of Philadelphia, to Lt. (j.g.) Jules H. Bogaev, Medical Corps, USN, son of Dr. and Mrs. Harry A. Bogaev, also of Philadelphia.

Marriages

MISS MARY ELIZABETH FREAS, daughter of Dr. and Mrs. Martin W. Freas, to Mr. Franklin E. Kepner, all of Berwick, June 10.

MISS SHIRLEY NORMA RAU, of Penn Wynne, to Mr. L. Roy Wilson, Jr., son of Dr. and Mrs. Lucius R. Wilson, of Wynnewood, June 17.

MISS BEATRICE ELFRETH, of Milford, Del., to Mr. G. Malcolm Laws, Jr., son of Dr. and Mrs. George M. Laws, of Philadelphia, June 10.

MISS ELSIE DUPUY GRAHAM HIRST, daughter of Dr. and Mrs. John Cooke Hirst, to Mr. William Toy Shoemaker Boericke, all of Philadelphia, June 2.

MISS JOAN MARIAN SCHAEFFER, of Summit, N. J., to Mr. H. John Sangmeister, Jr., son of Dr. and Mrs. Henry J. Sangmeister, of Penn Valley, June 10.

MISS AGNES HELENE CONNOLLY, daughter of Dr. and Mrs. John M. Connolly, of Philadelphia, to Capt. William Aloysius O'Connell, USAF, of Wyomissing Park, June 3.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ Horace J. Williams, Philadelphia; Jefferson Medical College of Philadelphia, 1912; aged 64; died June 3, 1950, following a short illness. Dr. Williams was elected professor of otology at Jefferson Medical College in 1939 and later became director of the department of otology at Jefferson Hospital. At the time of his death he also was director of the otolaryngological departments of Germantown Hospital, Memorial Hospital, Philadelphia Hospital for Contagious Diseases, and Jeanes Hospital. He was a Fellow of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological Association, the American Otological Society, Inc., and the American College of Surgeons. During World War I, he served in the Army Medical Corps as a first lieutenant. His widow and a sister survive.

Austin C. Frank, Pittsburgh; University of Pittsburgh School of Medicine, 1896; aged 76; died June 5, 1950, after a long illness. After practicing for 50 years, he retired three years ago and moved to the home of his daughter in Aurora, Ohio. He was on the staff at South Side Hospital for 35 years, being chief of the ear, nose and throat department when he retired. He was a Fellow of the American College of Surgeons. During World War I, he was a captain in the Medical Corps. Besides his daughter, he is survived by a son, two sisters, and two brothers.

○ Daniel A. Atkinson, Jr., West View; University of Pittsburgh School of Medicine, 1935; aged 39; died of a heart attack June 3, 1950. He practiced medicine in West View since 1936, when he succeeded his father, the late Dr. Daniel A. Atkinson, Sr., and was a member of the staff of Suburban General Hospital. Dr. Atkinson received the Air Medal for service as a captain with the Air Force during World War II. He was overseas with the 67th Bomber Squadron of the 44th Bomber Group. He is survived by his widow, a son, a daughter, a sister, and two brothers.

○ James N. O'Brien, Harrisburg; Georgetown University School of Medicine, Washington, D. C., 1930;

aged 44; died suddenly of a heart attack June 10, 1950. Dr. O'Brien was head of the cardiac clinic at Harrisburg Hospital, a post he had held for many years. He served with the Army Medical Corps from 1941 to 1945, holding the rank of captain. He was a member of the Harrisburg Academy of Medicine. Surviving are his widow, two sons, two daughters, his mother, a brother, and two sisters.

○ **Sterling F. Mengel**, Pottsville; Jefferson Medical College of Philadelphia, 1926; aged 48; was found dead June 2, 1950, with a rifle wound in his head. Dr. Mengel was a Fellow of the American Academy of Ophthalmology and Otolaryngology, and was secretary-treasurer of the Eastern Pennsylvania Association of Eye, Ear and Nose Physicians. He was a lieutenant commander in the Navy during World War II.

○ **William P. McCorkle, Jr.**, Pittsburgh; Jefferson Medical College of Philadelphia, 1933; aged 42; died May 28, 1950. Dr. McCorkle was on the staff of the Allegheny General Hospital. During World War II, he served in the European theater of operations as a captain in the 93d Evacuation Hospital. Besides his father, Dr. William P. McCorkle, Sr., Bridgeville, he is survived by his widow, a son, and two sisters.

○ **Charles H. Marks**, New Kensington; Hahnemann Medical College and Hospital of Philadelphia, 1923; aged 52; died May 14, 1950, following a cerebral hemorrhage. For the past five years he was senior and chief roentgenologist at Citizens General Hospital. Prior to that time he had served as school doctor for many years. He is survived by his widow, a son, a sister, and his mother.

Daniel S. Brazda, Blossburg; University of Pennsylvania School of Medicine, 1923; aged 54; died June 3, 1950, following a stroke. He had not practiced since 1937 when he suffered an initial stroke. Dr. Brazda was a former president of the Tioga County Medical Society. He served in World War I, and since then had been active in the American Legion and in civic affairs.

Joseph Head, Philadelphia; University of Pennsylvania School of Medicine, 1887; aged 88; died June 5, 1950, after a short illness. Dr. Head was also a dentist and before his retirement 20 years ago he served many years as head of the dental department at Jefferson Medical College. He is survived by his widow, two sons, and two daughters.

Charles Wagner, Hanover; Hahnemann Medical College and Hospital of Philadelphia, 1892; aged 82; died suddenly May 10, 1950. His death was attributed to a heart condition. He was Hanover's oldest practicing physician. Surviving are his widow, four sons, one daughter, two brothers, and two sisters.

○ **William J. Albright**, Highspire; Jefferson Medical College of Philadelphia, 1922; aged 52; died May 31, 1950, following a heart attack. He was Highspire's only practicing resident physician for more than 25 years. Surviving are his widow, a son, a daughter, and a brother.

○ **Elizabeth L. Ewing**, Philadelphia; Woman's Medical College of Pennsylvania, 1922; aged 81; died June

4, 1950. After many years of practice, Dr. Ewing retired about five years ago. She was found dead in bed.

Francis V. Gowen, Coatesville; Jefferson Medical College of Philadelphia, 1914; aged 61; died in the Veterans Hospital after a lengthy illness. He is survived by his widow, two sons, and a sister.

Miscellaneous

LeRoy M. A. Maeder, M.D., of Philadelphia, was re-elected secretary of the American Psychoanalytic Association at its annual meeting held in Detroit, Mich., April 28 to 30.

T. Grier Miller, M.D., of Philadelphia, was named first vice-president of the American Gastro-enterological Association at the fifty-first annual meeting of the group in Atlantic City on April 29.

ON JUNE 15 THE ONE HUNDRED-YEAR-OLD WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA conferred the honorary degree of Doctor of Laws on the Honorable **LeRoy E. Chapman**, M.D., of Warren, Pa.

Miss Esther Hottenstein, of Millersburg, daughter of Dr. and Mrs. D. Edgar Hottenstein, was graduated from the Woman's Medical College of Pennsylvania on June 15. She will intern at the Harrisburg Hospital.

George F. Potteiger, M.D., 82, of Hamburg, was honored by his fellow townsmen on May 17 when he completed 60 years of practice. Dr. Potteiger was graduated from Jefferson Medical College in 1890 and has practiced continuously in Hamburg.

Anthony F. De Palma, M.D., of Philadelphia, has been appointed James Edwards professor of orthopedic surgery at Jefferson Medical College. He succeeds Dr. James R. Martin, who retired to become emeritus professor.

Roy W. Goshorn, M.D., superintendent of the Holidaysburg State Hospital, is to be the new superintendent at Allentown State Hospital. He will succeed Dr. Harry F. Hoffman, who is retiring as head of the Allentown institution.

THE AMERICAN HEART ASSOCIATION has announced that a new section will appear in its monthly journal, *Circulation*, under the heading "Clinical Progress." This new feature, edited by Herriman L. Blumgart, M.D., professor of medicine at Harvard, will review the latest advances in the cardiovascular field.

THE READING EYE, EAR, NOSE AND THROAT SOCIETY held its sixth annual all-day meeting, June 21, at the Allentown Hospital. Subjects discussed included cataract surgery, nose and throat surgery, plastic surgery, endocrine studies in patients with cataract, and the present practice of otology.

Winslow T. Tompkins, M.D., of Pennsylvania Hospital, Philadelphia, has been awarded a research grant of \$22,500 for a three-year study on the significance of nutrition and nutritional deficiencies in human preg-

nancy. The grant was the largest of the twelve new semi-annual grants made for research in the field of nutrition by the National Vitamin Foundation.

THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY ANNUAL MEETING, held May 12 to 14 inclusive at the Bedford Springs Hotel, Bedford, was a great success from every angle of its comprehensive program. The complete program appeared on page 327 in the April issue of this JOURNAL. Among the newly elected officers are the following: president, Jay G. Linn, M.D., Pittsburgh; president-elect, Matthew Ersner, M.D., Philadelphia; secretary, Daniel S. DeStio, M.D., Pittsburgh; and treasurer, Bruce A. Grove, M.D., York.

THE THIRD ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF BLOOD BANKS will be held October 12, 13, and 14 at the Stevens Hotel in Chicago. The central location was chosen so that the meeting will be more accessible to members from all points of the country. The program which is being planned will be one which will attract blood bank personnel, hospital executives, pathologists, clinicians, surgeons, and other people interested in the procurement, preservation, and administration of blood and blood derivatives. For further information write the office of the secretary, 3301 Junius St., Dallas 1, Texas.

MEDICAL AND PREMEDICAL ADVISERS AND EDUCATORS interested in the problems of premedical education are invited to attend a national Conference on Premedical Education sponsored by Alpha Epsilon Delta, national premedical honor society, in cooperation with the Association of American Medical Colleges. The conference will be held at the Lake Placid Club, Essex County, New York, on Saturday and Sunday, Oct. 21-22, 1950, just prior to the annual meeting of the association at the same place, October 23-25. For further details and information regarding the conference, write to Alpha Epsilon Delta, 303 Upland Road, Havertown, Pa.

THE GRADUATE SCHOOL OF MEDICINE OF THE UNIVERSITY OF PENNSYLVANIA announces the establishment of a new course on Current Advances in Medicine and Surgery. This course will be given annually, the first session to be from Monday, September 25, through Friday, September 29. The tuition fee will be \$100 to physicians in general; alumni of the Graduate School of Medicine are exempt and pay only a registration fee of \$10. All fees are payable on application. Full information and application forms may be obtained through the Office of the Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia 4, Pa.

CARDIOVASCULAR DISEASE DIGEST AVAILABLE

A summarized report of the National Conference on Cardiovascular Diseases held in Washington last January under the sponsorship of the American Heart Association and the National Heart Institute is now available.

The 28-page booklet presents the highlights for the present knowledge and recent progress in the heart disease field as well as proposals for improved programs of research, prevention, treatment, management, and education as set down at the conference by a representative group of experts.

Single copies of the digest report may be obtained free of charge by writing to the American Heart Association, 1775 Broadway, New York 19, N. Y.

A FEW FACTS TO REMEMBER

While contemplating the entrance of government in the health affairs of the nation, we might well consider whether the government control proposed is apt to be beneficial.

We have just shown the tremendous surpluses in cotton, peanuts, etc. One would think the government might take thought to avoid the same condition in the future. Not so—the Congress, with the approval of the President, has increased the peanut planting by another 100,000 acres in spite of a 50 per cent overproduction. The same act provides that cotton planters may sow another 1,200,000 acres to cotton in spite of an oversupply of \$750,000,000 now on hand. These increases are subject to the same price support now provided. If the price falls below a certain fixed level, and that level is high, the government will buy and hold the commodities off the market. Rules and regulations insure that these acreages will be planted, for if a planter fails to grow his allotted acreage one year, he will be refused bonuses and government market if the next year he tries to go back to his original allotment without special approval.

Government control has shown itself to be inefficient and bunglesome. The British government loss on its nationalized railroads is running \$1,000,000 per week. During the first World War, government operation of the United States railroads cost the taxpayers \$2,000,000 daily. Under private operation during World War II the railroads paid the government \$3,000,000 daily in taxes.

Our previous assaying into the socialist state has been anything but reassuring. *We don't want any of it!*—*Journal of Michigan State Medical Society*, May, 1950.



EMPLE UNIVERSITY

THIS medical school is co-educational. Minimum requirements for admission are attendance for three academic years or its equivalent at an approved college of arts and sciences with satisfactory completion of the following courses: General Biology (Zoology with or without Botany), 8 semester hours; General Physics, 8 semester hours; General Chemistry, 8 semester hours; Organic Chemistry, 4 semester hours; English, 6 semester hours.

The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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For Sale.—Late model Jones metabolism machine. Used one time. Reasonable. Write J. EDWARD BOOK, M.D., Newport, Pa.

For Sale.—Modern fully equipped office and home with active established general practice. Will introduce. Location in Lancaster County. Leaving to specialize. Write Dept. 199, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Excellent general practice in town of 22,000. Hospital in town—open staff. Will introduce. Specializing. Write Dept. 202, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Excellent location in central Pennsylvania for general practitioner or surgeon. Some capital required, balance on terms. Income from start. Write Dept. 204, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Instruments, books, and office equipment of recently deceased physician who did general practice and eye, ear, nose and throat work. Write MRS. L. N. REICHARD, 306 Front St., Brownsville, Pa.

Wanted.—Physician licensed in Pennsylvania qualified to take over as Director of Anesthesiology in approved general hospital in Pittsburgh. Salary open. Write Dept. 212, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Established general practice in northwestern Pennsylvania manufacturing town. Four room office suite, fully furnished and equipped. Centrally located. Price of equipment covers all. Specializing. Write Dept. 195, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Physicians full time for vacancies on medical staff of large eastern railroad, permanent, class A graduates under 45. Salary \$5,640 per annum and rapid advancement. Write Dept. 193, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Pathologist, diplomate or qualified for board examinations, to associate with and succeed present director who is retiring soon. Modern, approved, 200-bed hospital. Write WASHINGTON HOSPITAL, Washington, Pa.

Wanted.—House physician, licensed to practice in Pennsylvania, for a general hospital in a small town. Salary and maintenance. Write Mr. WILLIAM H. MOORE, Administrator, Memorial Hospital of Chester County, West Chester, Pa.

Wanted Immediately.—Two house physicians for a 200-bed general hospital. Approved by the American College of Surgeons. These residencies offer a wealth of experience, good salary, and full maintenance. Apply SUPERINTENDENT, INDIANA HOSPITAL, Indiana, Pa.

Wanted.—Young doctor, Pennsylvania license, to assist in office Oct. 1, 1950 through Dec. 31, 1950 while partner is doing graduate work. Western Pennsylvania town of 4500. Write Dept. 210, PENNSYLVANIA MEDICAL JOURNAL.

For Rent.—Desirable modern office suite of recently deceased internist. Completely equipped. Ideal location in prosperous central Pennsylvania city. Excellent opportunity for young man. Write Dept. 211, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—General practitioner for community near Washington, Pennsylvania. Office, equipment, housing made available. Offers attractive future. Willing to discuss yearly guarantee. Write MR. WILLIS L. KENNEDY, Washington and Jefferson College, Washington, Pa.

Wanted.—Resident physician, July 1, or later in 1950, single or married, for general medical and surgical hospital. Approved by A.C.S. Near Wilkes-Barre. Excellent salary and duty schedule. Attractive living quarters. Further particulars furnished. Write SUPERINTENDENT, Nanticoke State Hospital, Nanticoke, Pa.

For Sale.—Combination home and office. Small town in eastern Pennsylvania. Some industrial work with salary. Other contacts available. Immediate possession. Good reason for selling. Excellent opportunity for young man. Price reasonable. Write Dept. 209, PENNSYLVANIA MEDICAL JOURNAL.

Wanted at Once.—Physician with Pennsylvania license for general and industrial bituminous mining practice. Near general hospital. Salary \$800 to \$1,500 a month. No investment needed. House available. Desirable community. Contact F. J. KELLAM, M.D., Indiana, Pa., Telephone—Indiana 374. (50 miles north of Pittsburgh.)

Wanted.—Recent graduate to take over general practice for one year beginning September, 1950, or February, 1951, in town 15 miles from Allentown, in cement and garment manufacturing section. Town and three-mile area has population of 25,000. Net yearly income \$20,000. Office and home equipped and furnished. Write Dept. 203, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—General practice with all supplies and equipment for price of equipment alone; includes 100 KV, 100 MA x-ray and fluoroscopic unit with all accessories. Office suite of six rooms in central location of small industrial community 30 miles west of Philadelphia. Price, \$5,000. Write Dept. 183, PENNSYLVANIA MEDICAL JOURNAL.

Opportunities for Physicians.—Are you interested in a position in one of our county or district health departments? Salary \$5,600 to \$7,200 with \$70 a month travel allowance. Public health scholarships available with liberal stipends. Men and women physicians eligible. Write FELIX J. UNDERWOOD, M.D., Mississippi State Board of Health, Jackson, Miss.

Wanted.—General practitioner for assistant to well-established and older Fellow of the American College of Surgeons. Married man desired. Good hospital facilities. Salary for first six months, then percentage. Apartment available in suburban area of twin cities. Great future. Minnesota license or national boards necessary. Write Dept. 207, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—General practitioner for town of McAlisterville. Located in Juniata County in agriculture and hatching section. Population of 600 with surrounding area including approximately 3000 persons. Civic leaders very interested in securing physician. New house available. For further information contact Mr. WAYNE W. GOODLING, McAlisterville Shoe Store, McAlisterville, Pa.

Part-time Physician Wanted.—Two hydro-electric companies having plants within twenty miles of Lancaster desire part-time services of young physician for employees and their families residing in or near companies' villages. Modern office and other equipment provided. Residence available in company village at reasonable rental. Private practice available in village and surrounding areas. Physician entitled to pension, hospitalization, life insurance, sick benefit, and vacation with pay. Address replies to Mr. J. U. DIEHL, P. O. Box 2076, Baltimore 3, Md., stating salary desired, age, education (including postgraduate training), experience, and date available.

Great Britain's newest political leader of first rank is a physician. He is credited with having had more to do with the recent upsurge in the fortunes of the Conservative party than Winston Churchill. If the Labor Government should give way to the Conservatives, he may become the Minister of Health and, says one reporter, "his skill with simple words may even carry him further than that."

The political ascendancy of Dr. Charles Hill, the 40-year-old General Secretary of the British Medical Association, was graphically described by Mr. Frank Gervasi in an article entitled "'Radio Doctor' Nearly Beat Attlee," which appeared in the *Washington Post* on March 19, 1950.

"Imagine the voluble Dr. Morris Fishbein," writes Mr. Gervasi, "swinging a national election in favor of the Republicans with a single radio broadcast, and you will begin to understand what happened here [London] on the crucial night of February 14."

Dr. Hill, a Tory, who was elected to Parliament in the February election, is a man of humble beginnings. He was one of four children born in the slums of Islington. His father, described by Mr. Gervasi as a "working man," died when Dr. Hill was three; thereafter his mother was obliged to go to work to keep the family going.

"His intimacy with a childhood poverty which he overcame by sheer toil," Mr. Gervasi continues, "undoubtedly helped him to be as effective as he was on that important February night in debunking the Labor Party's claims of the benefits it had bestowed on Britons during its five-year stewardship of the government."

"Putting on his best bedside manner and slipping familiarly into Cockney whenever necessary, Dr. Hill flayed Labor's performance in providing food, in administering the social services, in the housing field, and in national economics generally."

"Almost simultaneously, in Edinburgh, the Tory big gun, Churchill, was attacking Labor at a higher level, that of foreign policy."

"Between them, the radio doctor and the statesman squeezed the Labor majority down. . . ."

"Of the two, even Conservative political technicians admit now, nearly a month after the event, Dr. Hill was the more effective. For it was he, with language anyone could understand, who shook waverers' faith in the Labor cause, and it was the undecided fifth, the so-called 'floaters,' who plumped for the Tories at the last moment, who almost swept the Laborites out of power."

Before his advent into politics, Dr. Hill was known to millions of BBC listeners as the Radio Doctor. He became famous for "his bluff, gruff style and his penchant for calling a bowel a

bowel and for frequent references to 'the smallest room in the house,' one of his few euphemisms, by the way. His wartime fan mail was almost as voluminous as Churchill's."

"His outspoken comments sometimes raised minor storms," says Mr. Gervasi. "In 1945 he provoked the wrath of the International Wool Secretariat by declaring that 'wool next to the skin becomes soggy, like a wet blanket, while cotton or linen, if loosely woven or knitted, does not.' He denounced 'flannel undies' as no good, 'whether they're red or not.'"

"The Wool Secretariat declared Dr. Hill's assertions to be 'unscientific and unsubstantiated' and opined that his statements were 'likely to interfere with economic development along the lines on which the English people and the British Empire so heavily depend.'"

"There were, naturally, letters to the editor of the *Times*. Questions were asked in Parliament. But the Radio Doctor went calmly on with his broadcasts. When the political moment arrived, he had a ready-made audience."

Churchill, it appears, was impressed with the Radio Doctor. When the Conservative hierarchy proposed that the doctor speak during one of the few periods on BBC devoted to campaign politics, he "heartily approved." For the first time Dr. Hill dropped his anonymity (he had consistently avoided the use of his name in connection with his health broadcasts although his identity was generally known), and delivered himself as follows:

"It isn't as the Radio Doctor that I'm speaking tonight and it isn't about aches and pains or babies and backaches."

"It's politics. I came to the conclusion that the real issue is between socialism and freedom. . . ."

"The Socialists say that the death rate is the lowest ever, that the infant death rate is the lowest ever, that the death rate among mothers is the lowest ever."

"Therefore they say, vote for us, for we did it."

"You remember the old tag that figures can't lie, but liars can figure. Now the bald statements are true. The death rate is the lowest ever."

"But so was it in 1930, 1910, and 1905 as well. Dear me, the death rate, with a few minor ups and downs, has been going down steadily since the beginning of the century. . . ."

"I suspect it was due to M and B (new drug) rather than to M.P.'s (members of Parliament); to penicillin, not to politicians."

A bitter foe of socialized medicine, according to Mr. Gervasi, Dr. Hill "lost his battle merely because a majority of Britain's physicians joined the National Health Service, believing it to be a good thing for the people."

Dr. Hill is not so well known to physicians on this side of the Atlantic. Now that he is a public figure he will undoubtedly attract wide attention among his American colleagues. *Medical Annals of the District of Columbia*, May, 1950.



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BOOK REVIEWS

Transactions of Conference on Industrial Wastes, Fourteenth Annual Meeting. Pittsburgh: Industrial Hygiene Foundation, Mellon Institute, 1949. Price, \$2.00.

This is a handbook of helps on air pollution control, including the assessing of smog hazards in narrow valleys, chemistry of smog, and behavior of smoke from stacks, published by the Industrial Hygiene Foundation at Mellon Institute, and a copy has been added to our society's package-by-mail library service.

Dr. George D. Beal, assistant director of Mellon Institute, discusses stream pollution control.

Ward F. Davidson, research engineer for Consolidated Edison Company of New York, reduces to engineering terms, for the first time, theories on how stack dust and smoke are dispersed in relation to stack and building heights, gas velocity, temperature, and other factors influencing air pollution.

In discussing the ventilation of valleys, Prof. H. C. Willett of Massachusetts Institute of Technology disclosed that "once a smog is established, it tends to assist its own perpetuation." He discusses the weather conditions prevailing during the Donora episode.

Alex D. Bailey, vice-president of Commonwealth Edison Company, Chicago, says: "Regardless of the relative amount of industry's contribution to air pollution, industry must accept its due responsibility and through continuing effort and research must find ways of eliminating the nuisances it has created—public opinion demands it. We may think we have reached the economic balance today, but we can be assured that that too is a variable, a will-o'-the-wisp which we never quite reach. Industry should not wait to be driven to the point where relief is demanded. Industry must lead the way, and in addition to using the most improved methods and means for reducing air pollution, should support research leading to better ways and means. . . ."

A Manual of Cardiology. By Thomas J. Dry, M.A., M.B., Ch.B., M.S. in Medicine, Associate Professor of Medicine, University of Minnesota (Mayo Foundation); Consultant in Section on Cardiology, Mayo Clinic. Second edition, illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$5.00.

The author has taken the subject of cardiology and divided it into twenty chapters. Each is characteristically concise, informative, and essentially devoid of contro-

versial material. In his introduction on the approach to a patient with cardiac symptoms he recommends a tactful approach with a specific attempt to evaluate just what the patient means by each symptom. This is followed by an orderly and logical sequence of each phase of heart disease, bringing the products of extensive research to the point where the practicing physician can employ them clinically.

Throughout the text there are many illustrations, roentgenograms, and electrocardiograms which help crystallize the material under discussion. As to the latter, use is made of the standard limb leads supplemented by the Wilson unipolar precordial leads, especially those in positions 1, 3, and 5, and leaving further exploration to those cases in which the indication arises.

All in all, your reviewer recommends this book as a practical adjunct to the library of any student or physician interested in the treatment of patients with heart disease.

A Textbook of Neuropathology. With Clinical, Anatomical and Technical Supplements. By Ben W. Lichtenstein, B.S., M.S., M.D., Associate Professor of Neurology, University of Illinois College of Medicine; State Neuropathologist, Illinois Neuropsychiatric Institute; Attending Neurologist, Cook County Hospital; Professor of Neurology, the Cook County Graduate School of Medicine; Attending Neuropsychiatrist, Mount Sinai Hospital, Chicago. First edition. 474 pages with 282 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$9.50.

The author has succeeded in writing a textbook of neuropathology which will undoubtedly be highly praised. There is the intimate, direct, and highly personal touch of a teacher who, having completely learned his subject, is able to present it to the student in such an organized and attractive way that the acquirement of knowledge becomes a procedure to be enjoyed. One constantly sees evidence of painstaking care in the outlining, development, exposition, and transition to related subjects. Definitions are first introduced and then classifications are discussed before the subject proper is presented. This holds true not only for each chapter but for the format of the book as a whole.

One is introduced within the confines of neuropathology and neurologic nomenclature, which then leads into a statement on neuropathologic methodology. The pathogenesis of disease of the nervous system and

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neuropathologic alterations precedes discussion of the various conditions. These then include chapters on degeneration, regeneration, inflammation and inflammatory diseases, hemorrhage and vascular disorders, hydrops, hyperplasia, neoplasms, malformations, deformities and artefacts, adventitious and metabolic substances, and muscular disorders. There are three supplements—syndromes, paralyses, and uncommon diseases (114), also neuro-anatomic and neuropathologic technique supplements. The work is generously sprinkled with illustrations of both gross and microscopic specimens which are appropriate, illuminating, and well labeled. To those who might feel that the text itself is not sufficiently advanced, there are about 905 references advantageously placed in proper categories following each chapter. These are representative of both classic and modern papers.

Diseases of the Eye, Ear, Nose, and Throat. A Text-book for Nurses. By Albert P. Seltzer, M.D., Sc.D. (Med.), F.I.C.S., F.A.C.S., Assistant Professor in Otolaryngology, Graduate School of Medicine, University of Pennsylvania; Assistant Otolaryngologist to the Mt. Sinai Hospital, Philadelphia; Associate Chief in Ear, Nose, and Throat, St. Luke's Medical Center; Consulting Otolaryngologist to the Mercy-Douglas Hospital, Philadelphia; Instructor of Nurses at St. Luke's Medical Center. With the technical assistance of Bernard C. Gettes, M.D., Diplomate, American Board of Ophthalmology; Instructor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania; Instructor of Nurses in Ophthalmology, Wills Hospital; Chief Ophthalmologist, Stetson Hospital. First edition. New York: McGraw-Hill Book Company, Inc., 1950. Price, \$4.00.

The purpose of this book is to present in a comprehensive manner all the essential information about disorders of the eye, ear, nose and throat which would fall within the scope of the nursing profession. It attempts to present a coordination of the anatomy, physiology, and treatment of various phases in the field. Unfortunately, this is not adequately handled at all times. Furthermore, the author includes such subjects as x-ray technique, chemotherapy, and the use of isotopes which readers can find discussed more adequately elsewhere.

The following items are isolated examples of the sort of corrections this book will need should other editions ever become necessary: (1) Much of the writing is extremely fundamental and childish, even for student nurses. (2) Page 24 incorrectly defines the macula lutea. (3) On page 32 the near point should be defined with the additional phrase "with the eye at rest." (4) On page 38 examination of the lens is classified with the sclera and cornea, but it should be well known that the lens can only be best examined by the ophthalmoscope. On page 94 the impression is given

that photophobia means inflamed eyes. On page 114 the recommendation of a cocoon dressing is rather contrary to practice. And in general one may go on to say that in the treatment of tuberculous rhinitis no mention is made of streptomycin; cleft palate is not synonymous with harelip; oxycel is not an anticoagulant as it is called in the book; likewise, mastoid cells are not the antrum; lymph nodes are not glands; salivary glands are not lymphatics of the face and neck; capsule syringe should be replaced by carpule syringe; etc.

The authors are qualified men, but it is believed that they have not presented a book to be recommended.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Clinical Nutrition. Edited by Norman Jolliffe, M.D., F. F. Tisdall, M.D., and Paul R. Cannon, M.D., for the Food and Nutrition Board of the National Research Council. With 78 tables and 127 illustrations, 61 in full color. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1950. Price, \$12.00.

Sexual Deviations. By Louis S. London, M.D., Diplomate, American Board of Psychiatry and Neurology, Member of American Psychiatric Association, Fellow of the American Medical Association and other medical societies, and Frank S. Caprio, M.D., Member of American Psychiatric Association, Society for the Advancement of Psychotherapy, American Medical Association, and other medical societies. With a foreword by Nolan D. C. Lewis, M.D., Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Director of New York State Psychiatric Institute and Hospital; Editor of *The Psychoanalytic Review*. Washington, D. C.: The Linacre Press, Inc., 1950. Price, \$10.00.

Principles of Human Genetics. By Curt Stern, University of California, Berkeley. Illustrations by Aloha M. Hannah, University of California. San Francisco, Calif.: W. H. Freeman & Company, 1949. Price, \$7.50.

Parkinson's Disease. By Walter Buchler. Advice and aid for sufferers from Parkinson's disease and other physical disabilities. Published by Walter Buchler, 101 Leaside Crescent, London, N.W. 11, England. Price, \$1.00 net; \$2.00 cloth.

Breast Deformities and Their Repair. By Jacques W. Maliniac, M.D., Clinical Professor of Plastic Reparative Surgery and Associate Attending Plastic Reparative Surgeon, New York Polyclinic Medical School and



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THE ZEMMER COMPANY, Pittsburgh 13, Pennsylvania

Hospital, New York City; Attending Plastic Surgeon, Sydenham Hospital; Diplomate, American Board of Plastic Surgery. New York: Grune & Stratton, 1950. Price, \$10.00.

Harvey Cushing, Surgeon, Author, Artist. By Elizabeth H. Thomson. Foreword by John F. Fulton. New York: Henry Schuman, 1950. Price, \$4.00.

Textbook of Bacteriology. By Joseph M. Dougherty, A.B., M.A., Ph.D., Dean of the School of Science and Professor of Bacteriology, Villanova College; Fellow of the American Association for the Advancement of Science; and Anthony J. Lamberti, B.S., M.S., Instructor in Bacteriology and Parasitology, Temple University School of Medicine; formerly Instructor in Bacteriology, Villanova College; Member of the American Public Health Association. Second edition with 141 illustrations. St. Louis: The C. V. Mosby Company, 1950. Price, \$5.75.

Sex Without Fear. By S. A. Lewin, M.D., and John Gilmore, Ph.D. Foreword by Sarah K. Greenberg, M.D. New York: Lear Publishers, 1950. Price, \$3.00.

Amusing Quotations for Doctors and Patients. Edited by Noah D. Fabricat, M.D. New York: Grune & Stratton, Inc., 1950. Price, \$3.00.

The Merck Manual of Diagnosis and Therapy. A Source of Ready Reference for the Physician. Rahway, N. J.: Merck & Co., Inc., 1950. Price, regular edition, \$4.50; thumb-index edition, \$5.00.

Simplified Chemistry Experiments. By Armand Joseph Courchaine, Instructor in Biological Chemistry, Hahnemann Medical College, Philadelphia; Science Instructor, Hahnemann Hospital School of Nursing, Philadelphia; formerly Laboratory Supervisor, Human Serum Albumin Department, Sharp & Dohme, Inc., Glenolden, Pa.; formerly Analytical Chemist, the Barrett Division, Allied Chemical & Dye Corporation, Philadelphia. Edited by M. Cordelia Cowan. Illustrated by Richard Albany. New York: G. P. Putnam's Sons, 1950. Price, \$2.80.

The Ethical Basis of Medical Practice. By Willard L. Sperry, Dean of the Harvard Divinity School. With a foreword by J. Howard Means, M.D. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1950. Price, \$2.50.

A Primer for Diabetic Patients. By Russell M. Wilder, M.D., Ph.D., F.A.C.P., Professor and Chief of the Department of Medicine of the Mayo Foundation, University of Minnesota; Senior Consultant in the Division of Medicine, Mayo Clinic. (An outline of treatment for diabetes with diet and insulin including directions and charts for the use of physicians in planning diet prescriptions. Ninth edition. Philadelphia: W. B. Saunders Company, 1950. Price, \$2.25.

Textbook of Endocrinology. Edited by Robert H. Williams, M.D., Executive Officer and Professor of Medicine, University of Washington Medical School,

Seattle. With the collaboration of Peter H. Forsham, Harry B. Friedgood, John Eager Howard, Edwin J. Kepler, William Locke, L. Harry Newburgh, Edward C. Reifenstein, Jr., William W. Scott, George Van S. Smith, George W. Thorn, and Lawson Wilkins. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$10.00.

Clinical Orthoptic Procedure. A reference book on clinical methods of orthoptics. By William Smith, O.D., Associate Instructor in Optometry and Instructor of Orthoptics and Visual Training, Massachusetts School of Optometry, Boston, Mass. With 70 illustrations. St. Louis: The C. V. Mosby Company, 1950. Price, \$8.00.

The Causation and Treatment of Delayed Union in Fractures of the Long Bone. (This Jacksonian Prize Essay is published with the kind permission of the Council of the Royal College of Surgeons of England). By Kenneth W. Starr, O.B.E., E.D., M.B., B.S. (Syd.), M.S. (Melb.), F.R.C.S. (Eng.), F.A.C.S., F.R.A.C.S., Surgeon, Sydney Hospital, New South Wales; Visiting Surgeon, Concord Military Hospital; Consulting Plastic Surgeon, Faculty of Dentistry, University of Sydney; member of the Court of Examiners, Royal Australasian College of Surgeons; Lt. Col. (R. of O.), A.A.M.C., late Officer Commanding Surgical Division. London, England: Butterworth & Company. St. Louis, Mo.: The C. V. Mosby Company, 1950. Price, \$9.00.

Psychiatric Sections in General Hospitals. An Architectural Record Book. By Paul Haun, M.D., Med. Sc.D., Assistant Professor of Psychiatry, Georgetown University Medical School. New York: Architectural Record, 1950. Price, \$4.00.

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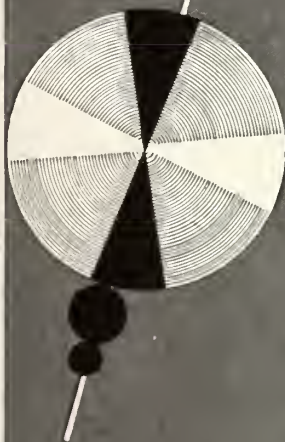
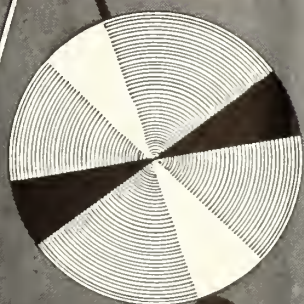
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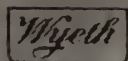
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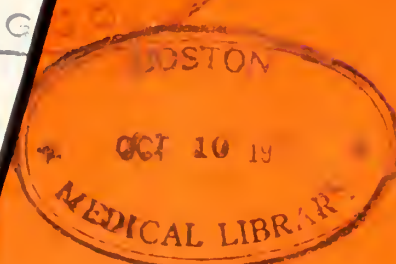
An Editorial

Toxemias of Pregnancy

Joseph J. Kocyan

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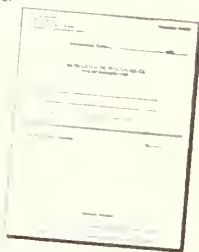


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LETTERS

Arthritis and Rheumatism Film

GENTLEMEN:

A motion picture for the medical profession is being made by the Arthritis and Rheumatism Foundation to provide a better understanding in the profession of the scope and status of the world's oldest, most widespread, and least understood chronic disease problem—arthritis and rheumatism.

The film, a 16 mm. color production with commentator, will review its incidence, its economic and social significance, the shocking lack of facilities for care, and the small sums available for medical research. Case histories of cortisone and ACTH treatments will stress the fundamental importance of hormone therapy as a guidepost to a fuller understanding of the disease processes in rheumatoid arthritis and gout. However, the limitations in the use of these hormones will be stated quite frankly. The fact will be emphasized that before the development of ACTH and cortisone the care of arthritis—though non-specific and largely preventative—was competently handled by interested men.

We feel that this film, produced under the supervision of the Foundation's Medical and Scientific Committee, will be of genuine interest to state and county medical societies. It would be extremely helpful if we could know in advance of your interest in using this film as stimulating study for the members of your affiliated societies.

The American Rheumatism Association, through its secretary, Dr. Charles Ragan, Presbyterian Hospital, New York 32, N. Y., will be glad to find a speaker to talk in conjunction with showings of the film wherever its members are available. In many states the Arthritis and Rheumatism Foundation has local chapters which will also help in organizing showings of the film and furnishing competent medical speakers.

Production on the film will be completed on or about Sept. 1, 1950, and the Foundation will lend copies to interested groups after that date. The only cost to the recipient will be for shipping charges.

GIDEON K. DEFORD, M.D., Medical Director,
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Hamblen, E. C.: Some Aspects
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North Carolina M. J.
7:533 (Oct.) 1946.



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cessive absorption may occur through relaxation of these precautions or through accidental heavy exposure. Physicians may therefore be confronted with cases of poisoning from this compound. The management of acute poisoning by a cholinesterase (CE) inhibitor is a medical emergency of a type seldom if ever up to this time encountered in medical practice. The following summary of information now available should therefore be of interest to physicians. From this it will be apparent that in this medical emergency the proper timing and dosage of the antidote atropine may be life-saving.

The systemic effects of parathion are qualitatively similar to those of other cholinesterase inhibitors, and to the effects of the acetylcholine analogues (pilocarpine, muscarine, arecoline, mechoyl, doryl). The effects of parathion are interpreted as the result of an accumulation of endogenous acetylcholine at synapses of the nervous system. They include giddiness, headache, nausea,

GEM FROM A DISTRICT COUNCILOR'S REPORT

"Communities with small hospitals are alerted to the efforts of osteopaths to use existing hospital facilities. The usual beginning is to ask for x-rays or other laboratory service. Those who either allege or follow in their practice a dogma which excludes demonstration and scientific experience should organize and maintain their own exclusive facilities for diagnosis and treatment." (See page 857, this issue.)

vomiting, abdominal cramps, diarrhea, miosis, sweating, salivation, lacrimation, confusion, weakness, and muscular fasciculations. A sense of tightness is felt in the chest as the bronchi constrict and fill with mucus. Fatalities appear to result from constriction and secretions in the bronchi or arrest of the heart. On the other hand, recovery from the acute poisoning is usually complete and uneventful. There has been no evidence of permanent injury in such cases.

Treatment may be effective if atropine grains 1/100 to 1/50 (0.65 to 1.3 milligrams) is given at once and every hour or oftener as needed to keep the patient fully atropinized (mouth dry, pupils dilated). If the lungs have filled before the atropine takes effect, clear the bronchi by postural drainage. Oxygen is then indicated. Morphine is contraindicated. Muscular fatigue and weakness may reach a degree requiring artificial respiration. Following even mild symptoms, no additional exposure to parathion or other phosphate esters should be allowed until time for cholinesterase regeneration has been allowed.

Intoxication by parathion or other CE inhibitors is an acute episode of 24 to 48 hours. It is terminated by cholinesterase regeneration and is followed by a period of gradually decreasing susceptibility to small exposures. Successive parathion exposures may deplete cholinesterase reserves progressively and create a susceptibility to small doses of tetra-ethyl pyrophosphate or vice versa. Since CE is regenerated rather slowly in man, patients who have suffered parathion poisoning should not be permitted to experience further possible exposures to this compound until it has been established that CE blood levels have returned to normal. Parathion and other phosphate insecticides are not locally irritating, but they produce local cholinergic effects. There has been no chronic or cumulative action other than that on CE as previously described. Dangerous parathion residues have not been detected on food crops sprayed at the proper stage before harvest.

D. O. HAMBLIN, M.D., Medical Director,
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For application and information about these and other courses, address: Office of the Dean, Post-Graduate Medical School, 477 First Avenue, New York 16, N. Y.

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THE *Pennsylvania* MEDICAL JOURNAL

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Number 8

An Appraisal of Some Analgesic Agents and Methods

EMANUEL M. PAPPER, M.D.

New York, N. Y.



THE CONTROL of pain is among the most important of the common problems faced by the physician in clinical practice. One might expect, as a consequence, that successful management of the various painful states might be easy of accomplishment if a large and diversified experience has significance in solving practical problems. Actually, as everyone fully realizes, such is not the case, largely because of almost insuperable difficulties in the precise evaluation of patients' complaints and the intelligent assessment of the role of a drug or other procedure in overcoming the pain syndrome. The real difficulties which obstruct the secure management of many painful states have led us into the comfortable rigidity of the routine administration of a preferred analgesic drug. Most patients are expected to respond to this type of therapy. Those who do not conform may find themselves labeled neurotic and unjustifiably dismissed from serious consideration. Furthermore, should a patient become seriously resistant to an analgesic régime, radical surgical correction may be recommended rather than an examination of the efficacy of the previously prescribed therapy.

One of the serious difficulties in understanding pain, and therefore in treating it intelligently, is the subjective, intensely personal reaction of the pain experience. Such commentary is justified even though systematic efforts to define the pain experience in objective terms have been prosecuted with great vigor, and have revealed helpful and interesting aspects of the control of pain. These inadequacies remain true even though the reaction pattern to pain includes many measurable responses, particularly alterations in activity of the several aspects of the autonomic nervous system.

A definitive evaluation of an analgesic method must rest upon the extent of the relief afforded to patients in unequivocal pain. Despite the large amount of data available from many excellent studies of the pain problem, there is no precise mode of evaluating an analgesic agent administered during significant clinical pain. Fortunately, studies in methodology, which are designed to establish with accuracy the efficacy of analgesic procedures under clinical rather than artificial circumstances, are in progress in several institutions. The results of such investigations will be awaited with eagerness by those interested in the control of pain.

Another general aspect of the analgesia problem is the method of development of new analgesic drugs and the more rapid enlargement of other analgesic avenues, among which are nerve block, surgical interruption of nerve pathways, physical medicine, and psychotherapy.

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 29, 1949.

From the Department of Anesthesiology, Columbia-Presbyterian Medical Center.

It seems likely, on the one hand, that drugs as potent in analgesia as the opiates will have either undesirable side effects (respiratory depression, gastro-intestinal dysfunction, or circulatory system changes) or addiction potentialities with chronic usage. It is probable, at least to this observer, that further extended search for potent analgesic drugs of the "morphine class" will not prove profitable clinically because of these liabilities. It is necessary, therefore, that the best of these drugs be reserved for the special circumstances suitable for them, particularly when addiction is not a hazard and untoward sequelae of drug action are not to be feared. A more precise comprehension of pain problems will suggest, if the experience to be cited below is indicative of other aspects of the situation, that milder analgesic agents have a definite role in therapy. The chemist and the pharmacologist are finding fruitful fields of study in the development of non-toxic active analgesic agents which can spare the clinician alternate waves of enthusiasm and depression attendant upon the current crude methods of trial and error.

With full recognition of the serious difficulties inherent in the pain problem, and an awareness of the insecure nature of defining the ultimate therapeutic efficiency of analgesic procedures, a critical discussion is presented of some of the more recent developments in the control of pain by conservative, non-operative methods.

A significant and interesting aspect of the management of painful states has been the administration of procaine intravenously. Although the current method of injection of dilute solutions (0.1 or 0.2 per cent) of procaine intravenously in the conscious patient is of recent origin to therapeutics, the principle of achieving pain relief with this drug by intravascular injection was realized shortly after its synthesis.¹ Analgesia of sufficient intensity for amputation can be secured under proper conditions of injection and the obstruction of active circulation to and from the extremity. The satisfactory interpretation of its effects in patients with pain is another problem entirely.

It appears, on examination of the clinical experience of several observers,^{2, 3, 4, 5} that procaine intravenously is an efficient analgesic substance in the control of pain associated with the trauma of burns, fractures, sprains, and surgical procedures. Less favorable has been the influence upon the pain of malignant disease, the several neuritides, and arthritis.

The mechanism of the observed analgesia has not been clearly defined. Some experimental support can be marshaled for the thesis of central action of procaine.⁶ The hypothesis that analgesia is the result of leakage from the vascular bed and the consequent bathing of free nerve endings⁷ is much less likely in the light of the admittedly incomplete evidence which is presently available.⁸

It may be that intravenously administered procaine is an analgesic method of importance in therapy. Whether or not such is the case is impossible to evaluate from the clinical material published because of the striking paucity of adequately controlled observations. One can say without question that many patients who received procaine intravenously received pain relief, but the critical problem as to whether the favorable influence upon the pain syndrome was wrought by procaine, psychic influences, inadequate definition of pain, or spontaneous remission is not as yet answered. Some of these difficulties in interpretation may be associated with a preconceived erroneous impression of the nature of a particular painful syndrome.

For example, it is a matter of general agreement among clinicians responsible for the care of surgical patients that significant pain in the post-operative period, especially the first two or three days, is a necessary though unhappy consequence of surgical manipulation. It is at this time that potent analgesic drugs of the opiate class are frequently administered in routine fashion. It is also in this period that evaluation of the effects of new agents or methods is usually completed. Such is part of the story of intravenously administered procaine.

As part of another study, an opportunity was presented to observe more adequately the nature and incidence of postoperative pain. Evidence which was gathered carefully and as objectively as possible indicated that pain after a variety of surgical procedures is absent in approximately one-third of patients and that it is severe in another third. The remainder of patients fall somewhere between these extremes. It is apparent, therefore, that a method for testing analgesic materials could not be accurate without satisfactory controls, nor is it entirely reliable even with the alternate case method because of the nature and incidence of postoperative pain as observed. The burden of proof was too difficult. Currently, studies are in progress to define clinical experimental circumstances which eliminate

or minimize the objections noted. Only then can rigid criteria for analgesia be established to define the clinical worth of an agent or method without equivocation. It is impossible, therefore, to accept uncritically the general use of a method such as intravenous procaine in the management of postoperative pain when the precise nature of the problem undergoing therapy is not established adequately. This criticism is equally pertinent when assessing the value of an analgesic method in lesions which are characterized by frequent or unpredictable spontaneous remissions.

It is not the present purpose to suggest to clinicians who are responsible for the therapy of patients with pain that intravenous procaine is without value. It may be a technique of permanent value in analgesia. However, the available evidence does not support this attitude unequivocally and suggests rather that the physician who employs this modality do so critically and with reservations of judgment. The unquestioned beneficial effects which are observed may be associated with factors other than the drug employed. Any means which affords help to patients is good therapy, but the mind of the physician must not be encumbered by attributing results to a chemical or a needle which more properly belong to his own personality. More controlled studies will furnish the answer to this problem.

Any discussion concerned with the evaluation of analgesic procedures must deal with the more recent applications of certain nerve block procedures to the management of pain syndromes. In large part, this group of methods is concerned with the deposition of procaine or some other local anesthetic agent in the vicinity of a tissue concerned with perception, conduction, or activation of a painful impulse. To the extent that precision in application, accessibility of tissues, and the desired time sequence of denervation can be controlled, these procedures are of value as aids in the control of pain. Some of the many procedures deserve comment since they are efficacious and can be directed against a group of painful conditions which are encountered frequently.

The widespread utilization of intercostal nerve block in the management of pain associated with rib fracture is a valuable analgesic procedure from many points of view. The problem in this injury is not due to analgesia alone, but represents the harmful systemic effects of pain in a vulnerable area of the body. Although it is perfectly true that simple uncomplicated rib fractures are not

problems in pain control or in survival with a minimal morbidity, the same cannot be said for multiple rib fractures, which are frequently associated with intrathoracic complications. Pain in the latter situation is not only uncomfortable but leads to impaired pulmonary ventilation, retention of secretions, and the ravages of infection and anoxia. The relief of pain permits improved ventilation and minimizes the potentiality of the morbid developments described. Pain relief obtained by immobilization or narcotic medication is attended by adverse effects on respiratory activity. Intercostal nerve block of the appropriate nerves, preferably by the paravertebral route, is an effective analgesic method which promotes rather than impedes respiration. Satisfactory pain relief and consequently satisfactory ventilation can be obtained with nerve block in more than 80 per cent of patients. A recent report of the experience gained in treating more than two hundred patients in this manner emphasizes a low mortality of 4.1 per cent.⁹ The procedure itself was responsible for only a single death. This is a procedure well worthy of further application as a significant method of providing comfort and a better chance of survival after thoracic wall injury. In this lesion, analgesia is the cornerstone of recovery with a minimum of complications.

Nerve block procedures have been applied recently to the pain of herpes zoster. It is difficult to evaluate results since the disease is usually self-limited and exhibits satisfactory responses to other modalities employed for analgesic purposes. However, it appears from the reports of most observers that satisfactory clinical responses may be anticipated in herpes of intercostal nerves, particularly if nerve block is performed as early as the skin lesions permit. Herpes involving other peripheral nerves, especially the trigeminal nerve and the brachial and lumbosacral plexuses, is usually refractory to the influence of nerve block. The post-herpetic neuralgias which persist in increasing pain intensity weeks after the skin lesions have recessed are particularly stubborn pain problems. An occasional patient can be relieved by nerve block or x-ray therapy. The majority are not helped even by potent narcotics in large dosage. Some patients in this refractory group have been subjected to radical surgical procedures in numbers too few for adequate evaluation. There is little else to offer these unfortunate people at the present time.

Another relatively new and simple procedure is the performance of suprascapular nerve block.^{10, 11} The block depends upon specific anesthetization of the suprascapular nerve which subserves sensation to the shoulder joint and its adjacent bursa. Suprascapular block is of symptomatic utility in the therapy of some instances of painful shoulder lesions. It appears to be most helpful in acute and intense instances of subacromial bursitis and less efficacious in the therapy of chronic shoulder disabilities. Under no circumstance does suprascapular block replace definitive care of the shoulder lesion itself. It is to be regarded as a valuable analgesic tool to be used in conjunction with other direct measures in therapy.

An extremely interesting and provocative approach to the therapy of the somatic aspects of cardiac pain has been developed recently by Travell and Rinzler and their associates.¹² These observers have extended the initial observations of Weiss and Davis¹³ relating to the therapy of visceral pain by local anesthesia of the somatic structures concerned in the perception of pain. The studies include the uncovering of the presence of zones of hypersensitivity or trigger areas in skeletal muscle. These trigger areas are in myofascial structures and produce a specific and characteristic reference of pain on pressure stimulation or needling. This pattern of reference is the same regardless of the activating cause of the trigger mechanism. The muscles involved in this phenomenon in coronary artery disease are the pectoralis major and minor and the serratus anterior. It is essential that careful palpation of muscles be carried out to ascertain the precise location of these trigger areas. The technique consists of infiltrating the hyperalgesia zones with a few cc. of 0.25 per cent or 0.5 per cent procaine or spraying the area with ethyl chloride. Best results are obtained in patients whose painful syndromes referred to somatic structures were precipitated by myocardial infarction. The least satisfactory effects were found in patients whose pain was a manifestation of effort angina either without infarction or preceding this accident. Although the theoretic explanations for these effects are far from clear, Travell emphasizes the fact that this type of pain can be managed satisfactorily in the clinic by infiltration of the trigger zones.

This type of study not only provides a new and simple means of managing difficult painful states but it also provokes a searching curiosity

into some of the more elusive aspects of pain. This is another example of the strange fact that the interruption of a pain cycle by procaine may lead to relatively permanent pain relief for long periods after drug action has ceased.¹⁴ It is suggested that closer study of the nature of this finding may be fruitful in elucidating some aspects of the pain experience hitherto unappreciated.

The principle of interruption of autonomic pathways in certain of the sympathalgias has been the object of recent study. The beneficial effect of sympathetic block in a variety of these lesions has been noted.¹⁵ The causalgic states have been explored most particularly from this standpoint.

The experiences with sympathetic block have been duplicated by systemic autonomic blockade with chemicals such as tetra-ethyl ammonium salts.¹⁶ Although some patients can be permanently cured by these methods, for the most part autonomic blockade is a diagnostic and prognostic aid for surgical section which is the definitive therapy in causalgia. Perhaps a word of comment is indicated on the relative merits of sympathetic nerve block and tetra-ethyl ammonium salts in these lesions. Although both methods can produce the desired effect, it seems more reasonable to employ nerve block at some time prior to operation. This represents a temporary section of specific pathways and will therefore furnish a more exact guide to the surgeon than can a diffuse total blockade of all autonomic synapses. It is possibly a small point of argument, but precision is of value in defining the extent of ultimate therapy.

A discussion of newer analgesic agents of value in the control of pain necessarily includes the recently developed morphine substitutes. In the intensive efforts to develop a substitute for morphine, hundreds of morphine derivatives have been made. Some like dilaudid have had clinical use. Another derivative which has excited clinical interest recently is metopon (methyl dihydromorphinone). Metopon is a potent analgesic, approximately twice as active as morphine, which appears to have fewer of the unfavorable side actions of morphine.¹⁷ In animals and in man it produces little sedation, euphoria, and emesis. With prolonged administration, tolerance and dependence develop more slowly than with morphine. A rather interesting property noted is the similarity of doses for analgesia for the parenteral and oral routes. These properties suggested to Eddy and his associates that meto-

pon could be used to advantage for the therapy of chronic pain since it can be administered orally with a minimum of side effects and a relatively long interval before tolerance and habituation were noted.

An unusual large-scale clinical experiment was sponsored by the Committee on Drug Addiction of the National Research Council in which orally administered metopon was made available to physicians for the therapy of cases of terminal malignancy. These reports were studied by Eddy¹⁷ and published. Pain relief, as judged by many physicians, was satisfactory in 74 per cent of all the trials. Mental clarity was maintained in an equal number. Side reactions were not noted in 2096 patients or 90 per cent of the total. Nausea was the single largest offender and this of minor incidence in this large group of patients. It was observed that the best analgesia was obtained in patients who had received no previous medication. Eddy pointed out that metopon is difficult to manufacture and expensive. Its expected limited supply indicates that it will not replace morphine in many instances. Its use, for example, in pre- and postoperative medication is discouraged. Its specific advantages lie in the therapy of ambulatory or semi-ambulatory patients with chronic pain requiring a drug of morphine-like potency. If it is started before tolerance to other narcotics has occurred, the oral administration of metopon in 6 mg. doses at intervals spaced as widely as possible will provide adequate pain relief for weeks or longer without side reactions and with minimal tolerance and dependence.

However, even this modest expectation must be taken with caution. Houde et al.,¹⁸ in an intensive and careful study of 5 patients with carcinoma, were able to report adequate analgesia in but one of these, even with larger doses than recommended by Eddy.

Of the many synthetic compounds which are potent analgesics, two have assumed clinical importance in recent years, meperidine or demerol, and methadone.

Meperidine has been in clinical use since its synthesis by Eisleb and Schaumann in 1939.¹⁹ Although it was first investigated for its spasmolytic properties, these soon assumed secondary importance to the effective analgesic actions which can be substituted for morphine. Although it is active orally, it is more effective parenterally. Meperidine differs in important respects from morphine. It causes much less depression

of respiration (except in the aged and in patients with expanding intracranial masses), no suppression of cough, little euphoria, and fewer toxic symptoms. In general, it may be contrasted with the action of morphine on smooth muscle tone in the gastro-intestinal tract. Except for the sphincter of Oddi, meperidine relaxes intestinal smooth muscle.²⁰ Batterman²¹ has shown that mild toxic effects, e.g., dizziness, are very common in ambulatory patients and rare in hospitalized patients. Addiction and tolerance do occur but much less so than with morphine. Meperidine is of great value in preoperative medication, in the control of postoperative pain when present, and for analgesia in obstetrics. This drug, valuable though it is, is still not the ideal potent analgesic because of its definite addiction potential and its limited safety in aged patients with pain. However, it merits the widespread usage it enjoys at the present time.

Methadone is one of the most recent developments of the synthetic chemist for the production of analgesia. Originally produced in Germany during the war as a morphine substitute, methadone has been studied extensively by Chen and Scott and their co-workers in this country. Chen has recently summarized the available data.²² Methadone exerts many pharmacologic actions which are strikingly similar to morphine. It produces analgesia at least as profound as that of morphine in similar doses. Nausea, emesis, and constipation are its most frequent untoward consequences. The question of tolerance and addiction has been a matter of some dispute,^{23, 24} but the prevailing evidence suggests that the possibilities of these undesirable effects are real. However, there are differences between methadone and morphine which appear to offer utility to the clinician in favor of methadone. Therapeutic doses of methadone cause less circulatory depression, less sedation, less respiratory depression, and infrequent euphoria in non-addicts as contrasted with morphine. Methadone appears to be valuable in the therapy of painful states which require a drug as potent as morphine. It does not seem advantageous in preoperative medication²⁵ because of its lack of euphoria, nor is it safe in obstetric analgesia because of the depression of fetal respiration.

Summary

A brief review of some methods and agents of value in the control of pain has been presented. It is suggested that these be considered critically

with regard to clinical application because of the serious difficulties inherent in the accurate and precise evaluation of any method in the treatment of pain.

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THE HOSPITAL BOARD OF TRUSTEES

At the fifteenth annual meeting of the American College of Hospital Administrators last year, two papers were read which provoked much comment, and so much interest was manifested that the addresses were printed and distributed among the membership.

In the ordinary connotation "trustee" is synonymous with "director," and for the purpose of this editorial they are so considered. To the title of one paper, "Are Hospital Trustees Needed?," the answer is an emphatic yes, provided they are capable trustees. These officers should be selected with the same care that a board is chosen for a bank or a university, because they represent, in a personal manner, the institution as it stands before the community. The board is the hospital's sponsor. The type of individuals who compose the board raises or lowers the standing of the institution in the estimation of the public, and its prestige can only be maintained by the lofty character of its membership.

They should not be chosen to serve in the role of a member because of an abundance of leisure, social position, or unlimited financial resources, but rather for their sound business training and reputation for integrity and capacity for work. Women with these qualifications make excellent members. The composition of the board should be a cross-section of the citizenry and should include, among others, a lawyer, a financier, a member of the clergy, an executive, a man engaged in a small business or employed in one, and above all, ample representation from the medical profession. All too often the staff of the hospital has a small voice in hospital management, a situation that overlooks the fact that the institution could not exist without patients and every patient must have a doctor.

Election or appointment of members of a board of a hospital should not be a casual matter. Before one is considered it should be ascertained that he is interested and that he will attend the meetings faithfully. Too often names are added merely to decorate what appears

to be an impressive membership while, if the truth were known, it is often impossible to have a quorum present at the stated meetings. What every hospital needs is an energetic and enthusiastic board, one that takes its responsibilities seriously without hope of any material compensation. It is possible to obtain such members, since in every community there are a large number of men and women deeply interested in this humanitarian endeavor.

The other paper which received much favorable comment was "As a Trustee Sees His Stewardship." This developed many side lights in the duties of a trustee. A deep-rooted opinion seems prevalent that the chief duties of a director or trustee are to raise funds for the institution and to defend it when it is the target for captious criticism. The board of directors in its relation to the administrator is somewhat analogous to that of the Congress to the President of the United States (as provided in the Constitution).

The director should assist in obtaining able personnel in establishing and maintaining internal and external policies, promoting good public relations, and guarding the resources of the institution. He should take a keen interest in the financial affairs, scrutinize the reports, ask pertinent questions, and make appropriate suggestions concerning the major affairs of the hospital. He should accept appointments to special committees and make constructive reports. It is not necessary that he should be particularly vocal in the meetings, for it has been truly said that the empty vessel makes the greatest sound. As a member of the board he should protect the interests of the public as well as the hospital, because he is truly a liaison officer between the community and the hospital. For this and very much more, he will get no compensation and little thanks, but as a trustee he has received a liberal education in human behavior and understanding of the brotherhood of man, and this reward is enough.—*Medical Annals of the District of Columbia*, June, 1950.

Reconstruction of the Common Bile Duct

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WHEN AS a young surgeon I watched one of the most distinguished of American surgeons do a cholecystectomy, I noted that he started the dissection at the fundus and continued it to the junction of the cystic and common ducts. Having assisted Dr. Deaver while that master did many cholecystectomies, I had been trained to do the operation by starting the dissection at the cystic-common duct junction. I inquired why the fundal technique was being used and was told that with this method injury of the common duct never occurred. In spite of this, a few moments later he asked me to come closer to look into the wound, and when I did so, he showed me that he had inadvertently divided the common bile duct.

Two lessons can be learned from this experience: the first of these is that no one method guarantees against ductal injury; and the second, that even the most erudite of surgeons will at times injure the ductal system. While stricture may occur from several causes, trauma is by far the commonest cause.

There can be no doubt but that, as biliary tract operations increased in frequency, common duct injuries increased in frequency; and similarly, as cholecystectomy more and more supplanted cholecystostomy, common duct trauma became more frequent. There are other circumstances which played some part in the frequency of these tragedies. Until the mid-twenties, the young surgeon began his training in the anatomic laboratory. He had a profound knowledge of anatomic relations and a fair knowledge of pathology. He knew little or nothing of the newer sciences of physiology and biochemistry.

With the rapid expansion of our knowledge of normal function, and the abnormalities imposed by disease, young surgeons began to look to physiology and biochemistry as the cornerstones upon which a surgical career should be founded.

Training in anatomy was relegated to the background. With improvements in anesthesia, less attention was given to completeness of exposure of the operative site. Finally, after each of our World Wars there has been an increase in the number of men doing civilian surgery who have been inadequately trained. When Mr. Rodney Maingot visited us last year, he told us that he had seen more benign strictures of the common duct in a month in this country than in a lifetime in England.

The tragedy of these injuries is that the great majority of them need not have occurred if the surgeon had had adequate exposure of the cholecystic-common duct area, and if he had realized constantly the frequency with which anomalies of the ductal and vascular system are encountered.

An additional cause of the frequency of injury of the common duct is the attempt to stop bleeding from the cystic artery when this artery is torn or slips from the hemostat which has clamped it. In the attempt to catch the bleeding vessel in a pool of blood, the common duct is often injured.

The tendency to place too much tension on the neck of the gallbladder during cholecystectomy, in order to straighten the cystic duct, tends to pull out a funnel-shaped portion of the common duct. When clamped and tied, in the belief that it is the cystic duct, there occurs a defect in the common duct as soon as tension is released.

It is an unfortunate circumstance that even the best of our anatomic textbooks do not stress the great frequency of anatomic variations of the extrahepatic biliary passages. One of the most commonly used texts states that the so-called normal relation is found in 87 per cent of individuals. It has been my own experience that the junction of a moderately long cystic duct at an acute angle with the common duct occurs in less than 40 per cent of patients. In the remainder, one of a variety of abnormalities from the so-called normal will be found to be present.

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From the Surgical Clinic of the Hospital of the University of Pennsylvania and the Harrison Department of Surgical Research, Schools of Medicine, University of Pennsylvania.

One should always suspect an injury to the common or hepatic ducts when, following operation, there occurs a continued flow of bile from the wound. As a stricture forms, the patient will become jaundiced, and as infection develops proximal to the stricture, cholangio-hepatitis is manifested by chills and fever.

The most fortunate circumstance that can happen to a patient whose ductal system has been injured is the recognition of this at the time of injury. Reconstruction then is, as a rule, a relatively simple matter. Direct end-to-end anastomosis, over some type of prosthesis, should be done. At the line of suture, care must be exercised to obtain direct mucosal approximation. Failure to obtain this is a frequent cause of recurrence of stricture formation. The prosthesis—be it a catheter, a T tube, or any other substance connected to the skin—should never be brought out through the line of suture. The prosthesis, if removable, should remain for several months or even longer, care being taken to prevent its becoming plugged by cholesterol-bile pigment precipitates. The unfortunate thing is that most ductal injuries are not immediately recognized and therefore not immediately repaired. Repair at a later date is often difficult and the end results have frequently not been satisfactory.

Since Jan. 1, 1946, there have been 31 patients admitted for operation to the Surgical Clinic of the Hospital of the University of Pennsylvania with an injury to the common or hepatic ducts, or both. Forty-six operations were performed on them. There have been no deaths in this group. In Lahey's entire series of 227 patients the mortality was 11.9 per cent, while in the 139 patients operated upon since 1943 the mortality was 8.6 per cent.

The types of injury have been varied. In some instances the right hepatic duct has been divided. In others, the common hepatic, and in still others, the common duct itself has been injured. In some the area of stricture was small, while in others it has been impossible to find the distal end of the divided duct even after a most careful search. Some of these patients have been sent to us within a few days of injury, while others have had many operations, all of them ending in failure. I should say here that, before any type of operation is decided upon, the surgeon should exhaust every possibility of finding the proximal and distal ends of the ducts. The dissection should be continued up into the hepatic hilus and

down behind the duodenum and into the pancreas. Nothing gives the patient a better chance of permanent recovery than to find both ends of the injured duct and carefully bring them together.

It is unfortunate that following repeated operations for the relief of a benign stricture it is often not possible to bring the ends together as I have described. In such circumstances one of a variety of operations can be tried. None of these is so frequently successful as that which I have just described, but each has been used by us at times when the condition found at operation made it impossible to use the more favorable procedure.

In the past ten years we have not used the Williams-Lilienthal operation of transplanting an external biliary fistula into the stomach or the bowel. In previous years it gave uniformly poor results.

The operation of choledochoduodenostomy or choledochojejunostomy is at times a satisfactory procedure. This is especially true when the proximal end of the duct is sufficiently dilated to obtain a good-sized opening (1.5 cm.), and when accurate mucosal suture is possible. It is not as satisfactory as is the defunctionalized jejunal loop anastomosis suggested by Allen and Cole and their associates. It is at times difficult to mobilize the duodenum sufficiently to obtain a satisfactory anastomosis. If the jejunum is used, the defunctionalized loop suggested by Cole and by Allen is the better procedure.

The major difficulty with all operations of this type is the tendency for the anastomotic opening to become cicatrized. Studies made in our laboratories by Fitts and his associates have demonstrated that in all instances some degree of cholangio-hepatitis follows these operations. As cicatricial stenosis of the anastomotic site occurs, the infection becomes more active and more

RECONSTRUCTION OF BENIGN STRICTURES OF THE
COMMON BILE DUCT CASES AT H. U. P.
(1945 TO DECEMBER, 1949)

	<i>Number of Patients</i>	<i>Number of Operations</i>	<i>Mortality</i>
Dr. Ravdin ...	11	13	0
Other surgeons at H. U. P. .	22	33	0
Total (minus the overlap)	31	46	0

virulent, resulting in widespread liver injury. The initial enthusiasm which greeted the use of the defunctionalized jejunal loop has given way to increasing skepticism as we have seen these patients, too, come back with repeated attacks of cholangio-hepatitis and jaundice.

We have used prostheses of rubber, vitallium, and certain plastics. None has proved uniformly satisfactory. On a theoretic basis, Grindlay's work on plastic prostheses was most promising, for it seemed possible that the use of a non-wetting surface would prevent the formation of the cholesterol-pigment precipitate that almost invariably leads to failure when other substances are used for the prosthesis. But the fundamental cause of precipitate formation is a change in the ability of the hepatic parenchyma to excrete a bile in which cholesterol is beautifully held in solution as it is in normal bile. In the presence of liver injury, bile salt synthesis is interfered with and cholesterol precipitates come out of the bile in variable amounts. When to this is added the fact that such prostheses all too frequently pass into the gut, we know why these methods are of only limited value.

Longmire recently suggested anastomosing the intrahepatic portion of the left hepatic duct, following its exposure in the left lobe of the liver, to the jejunum. Rogers, in my department, has been investigating a somewhat similar technique except that in his procedure the left hepatic duct is exposed within Glisson's capsule. It is amazing how much of the duct, proximal to its junction with the right hepatic to form the common hepatic, actually is outside of liver parenchyma. The suggestions of Longmire and Rogers are interesting, but they can be adopted only when the proximal portion of the common hepatic duct remains, for otherwise the right duct bile cannot gain entrance into the left duct. It is very likely that after a period of apparent success these procedures, too, will be followed by a high incidence of recurrences.

For many years, surgeons have heatedly debated the value of the sphincter of Oddi in preventing ascending cholangitis. Some believe that cholangitis will inevitably occur without an intact sphincter, while others believe that cholangitis occurs only in the presence of obstruction and is prevented by the maintenance of a free flow of bile into the intestinal tract. This question often is of practical importance in determining the best type of operation for bile-duct strictures. Preservation of the sphincter mechanism may greatly

increase the difficulty of operation. If the sphincter is not necessary, then an easier operation (such as choledochoduodenostomy) is justified.

During the last two years Fitts and his associates have carried out experiments on dogs to determine the value of the sphincter in preventing ascending infection. By exposing the bile ducts to the virulent flora of the colon, a more severe infection results than by exposure to the flora of the upper intestinal tract, and any protective action afforded by the sphincter should be more clear-cut. Direct continuity was established between the biliary tract and the colon, both with and without an intact sphincter. The results showed definite evidence of protection from ascending infection afforded by the sphincter.

Because of these experimental results and our clinical observations, we try in every instance to preserve the sphincter in bile duct reconstructions. When the stricture is long, it may be difficult to find the distal end of the duct, or to anastomose it to the proximal duct without excessive tension. Lahey and Cattell have been able to effect direct anastomosis in almost all instances, however, by mobilizing the duodenum and, if necessary, splitting the head of the pancreas for identification of the distal end of the duct, and our experience strongly confirms their observations.

If these maneuvers are not successful, it may be feasible to bridge the gap by using an isolated loop of jejunum. This method, suggested by Dr. Charles Kirby of our staff, provides a continuous mucosal lining with good blood supply and should prevent recurrent stricture formation—a common occurrence when the gap is bridged by foreign material or by a graft of fascia or omentum. Although we have not yet found occasion to use this operation on humans, it has been performed successfully on several dogs followed for more than a year.

Those who have worked in this interesting, even though discouraging, field are agreed that there is no substitute for an intact sphincter of Oddi. If it is to be used, the ends of the ducts must be freed from surrounding scar, and end-to-end suture with careful mucosal approximation obtained. Only in this way can the largest percentage of these patients be assured of a permanently satisfactory result.

These patients, debilitated by prolonged nutritional deficiencies, by variable degrees of hepatic insufficiency, by fluid and electrolyte imbalances, and by prothrombin deficiencies which predis-

pose to postoperative hemorrhage, need the most careful preparation for operation. A diet adequate in composition and in calories fed by mouth, if at all possible, is necessary. It is comforting to know that the liver will regenerate even under the adverse conditions of stricture and infection if an adequate diet is provided. Vitamin K, fluids, and electrolytes must be ad-

ministered to overcome any deficiency. Finally, the operation is made safer if the blood volume is restored.

The morbidity and mortality of these operations will depend not only upon the operation but also upon the thoroughness and intelligence with which the preoperative and postoperative care is conducted.

NAVY ASKS INACTIVE RESERVE MEDICAL CORPS OFFICERS TO VOLUNTEER FOR ACTIVE DUTY

Due to the shortage of physicians to meet the present-day obligations, the Surgeon General of the Navy, Rear Admiral Clifford A. Swanson, asks that these members of the inactive Naval Reserve volunteer immediately for extended active duty. Medical officers in the ranks of commander and below will be accepted.

The recently authorized increase in the over-all manpower strength of the Navy requires the services of additional Medical Department personnel to serve in the continental United States and overseas.

Members of the reserve components volunteering for active duty should apply to the Chief of Naval Personnel, Navy Department, Washington 25, D. C.

Qualified civilian physicians may apply for active duty in the Medical Corps of the U. S. Naval Reserve. They will be commissioned in ranks up to and including lieutenant commander, depending upon age and professional experience.

Interns in civilian hospitals are urged to apply for a commission in the rank of lieutenant (junior grade) in the Navy Medical Corps Reserve and have the remainder of their intern training sponsored by the Navy.

For additional information regarding commission and appointment, application should be made to the nearest Office of Naval Officer Procurement.

The State laboratories in Philadelphia, Pittsburgh, and Wilkes-Barre will change to this technique in the very near future.

The VDRL test is a flocculation technique developed by the Venereal Disease Research Laboratories of the United States Public Health Service. Cardiolipin antigen is employed in the test, which may be performed by the slide or tube technique. It is very sensitive and therefore excellent as a screening test and at the same time is as specific as any of the other commonly used flocculation or precipitation tests.

The slide technique will be used by the Bureau of Laboratories, State Department of Health. All specimens showing any degree of reaction will be further confirmed by a complement fixation test. The VDRL quantitative technique will be substituted for the presently used Kahn quantitative technique.

The results of the VDRL test are reported only as "negative," "weakly positive," or "positive." Quantitative results are reported in "dils," indicating the highest dilution of serum in which a positive reaction is found. For instance, if a serum gives a positive reaction in a dilution of 1 to 32, it would be reported as "positive, 32 dils." Those accustomed to the Kahn quantitative technique will find this method of reporting strange at first, since the Kahn figures are very often of a much higher order.

STATE HEALTH DEPARTMENT ADOPTS VDRL TEST

Norris W. Vaux, M.D., State Secretary of Health, has secured tentative approval from the members of his Advisory Health Board for the adoption of the VDRL test as an approved technique for the performance of serologic tests for syphilis in premarital and prenatal cases. At the next meeting of the Advisory Health Board this tentative action will be ratified.

Directors of approved laboratories throughout the State have been notified of this action, and are now at liberty to use this technique if they so desire. However, they are reminded that in premarital and prenatal cases both a flocculation and a complement fixation test are required.

KEEP YOUR PATIENTS POSTED

A strategically placed bulletin board in the physician's waiting room serves the double purpose of telling your message to the patient and providing welcome diversion while he waits. Hanging a bulletin board is as easy as hanging a picture. There's a wide variety of material for posting—information on compulsory health insurance, newspaper clippings about England's costly national health insurance, and health items of general interest. Don't forget cartoons. And don't forget to change the material often.

"The best thing about a bulletin board," says one physician, "is that it makes patients ask questions. It gives me the conversational opening I need to explain more fully where I stand on compulsory health insurance—and why."—*Journal of the Oklahoma State Medical Association*, June, 1950.

Recent Advances in the Surgical Treatment of Carcinoma of the Esophagus

A Discussion of Cervical Esophagogastrostomy

FRANK F. ALLBRITTEN, JR., M.D., and JOHN H. GIBBON, JR., M.D.

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A SATISFACTORY treatment for carcinoma of the lower three-quarters of the thoracic esophagus has been developed in the past decade. After the first successful resection for carcinoma of the thoracic esophagus by Torek in 1913,²⁰ esophagectomy combined with esophagostomy and gastrostomy was rarely reported. The re-establishment of the oral-gastric canal often proved to be impossible and, at best, a prolonged series of plastic procedures was required to accomplish this feat. In 1937 Marshall accomplished the first successful transthoracic gastric cardiotomy and esophagogastrostomy in the United States,¹³ though this report was preceded by the report of a successful similar operation in 1938 by Adams and Phenister.¹ Subsequently it became evident, largely through the work of Garlock⁸ and Sweet,¹⁵ that by severing all extralimentary gastric attachments except the right gastric and right gastro-epiploic vessels the stomach could be brought through the diaphragm to reach the apex of the thorax. Lesions of the esophagus located immediately below or behind the arch of the aorta required transplantation of the proximal esophageal segment lateral to the aorta and a supra-aortic esophagogastric anastomosis. The difficulty of the anastomosis above the aortic arch was reflected by a considerably higher incidence of complications as well as a mortality rate of approximately 25 per cent.¹⁸

Neoplasms of the esophagus situated between the aortic arch and the pharynx presented more difficult problems. The height of the lesion was thought to eliminate the possibility of anastomosing the stump of the esophagus with stomach or small bowel transplanted from the abdomen.

Consequently, lesions at this level were generally treated by esophagostomy and gastrostomy, followed by multiple plastic procedures in an attempt to restore the continuity of the oral-intestinal tract. In July, 1948, Garlock⁹ reported the treatment of a patient with a lesion located in the superior mediastinal segment of the thoracic esophagus by resection and a cervical esophagogastrostomy in January, 1947. This patient died on the first postoperative day. In April, 1948, Sweet reported a successful resection of an esophageal carcinoma in October, 1947, with a cervical esophagogastric anastomosis made after the stomach had been pulled through the superior thoracic inlet following partial resection of the left first rib and left clavicle. This patient survived.¹⁹

Other methods of restoring the continuity of the oral gastric tract in patients with carcinoma of the cervical esophagus have been described. Wookey²² used a procedure in which a flap of skin from the cervical area is reflected laterally. The cervical esophagus containing the neoplasm is resected. The skin flap is then placed in the bed of the cervical esophagus and sutured to the proximal and distal ends of the esophagus. Sweet, Watson and Pool,²¹ and others have reported successful cases in which this technique has been used. Lesions limited to the cervical esophagus may be resected by this method, but those extending into the superior thoracic inlet are beyond its scope. The extent of the resection is limited, the regional glands in the superior mediastinum are not exposed, and the recurrence rate is high. Bricker et al.³ have reported a method in which a pedicled flap has been fashioned from the integument of the upper thorax. The flap is transplanted into the thorax and anastomosed to the proximal and distal esophag-

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From Jefferson Medical College Hospital and Barton Memorial Division of the Jefferson Medical College Hospital.

eal segments through a combined cervical and thoracic approach.

In addition to these methods which have been successfully used, there have been numerous reports of transplantation of the stomach or segments of the small bowel in the subcutaneous tissue from the abdomen to the cervical region.²⁴ Longmire and Ravitch²¹ have devised a method of encasing a segment of jejunum in a pedicled skin tube which is then placed in the position required. In a second method devised by Longmire¹² the jejunal segment is placed in the antethoracic subcutaneous tissue and an anastomosis is made between the internal mammary artery and a vessel in the transplanted jejunal mesentery. Harrison¹⁰ has recently reported transplanting a segment of jejunum transthoracically into the cervical region and performing a pharyngo-jejunostomy in a child with a lye stricture of the cervical esophagus. This method is similar to one previously reported by Rein-hoff.¹⁷ Each of these methods possesses some advantages. The procedures in which flaps of cutaneous tissue are made involve multiple staged procedures, requiring prolonged hospitalization, and the morbidity and mortality associated with any operative procedure. For this reason we have preferred to use the single stage combined cervical thoracic approach with direct anastomosis of the stomach and the proximal end of the esophagus or pharynx.^{2, 16, 23}

Preoperative Preparation

Before any operative procedure is considered, a careful evaluation of the patient is required.

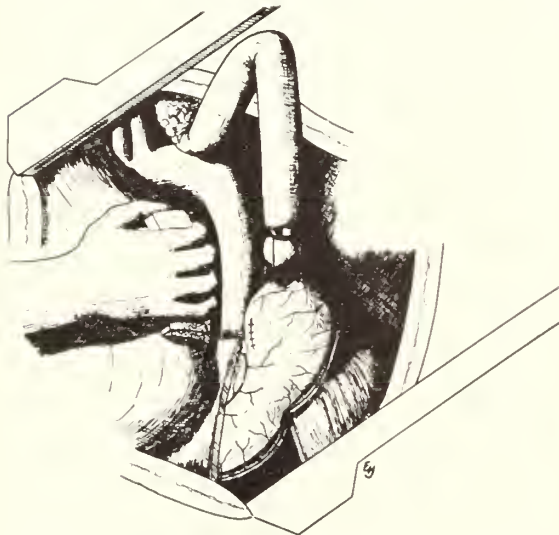


Fig. 1. The distal end of the esophagus is inverted into the stomach. The proximal end of the esophagus has been mobilized and transplanted lateral to the aortic arch. Circumferential ties about the esophagus are then sutured to the fundus of the stomach as traction sutures.

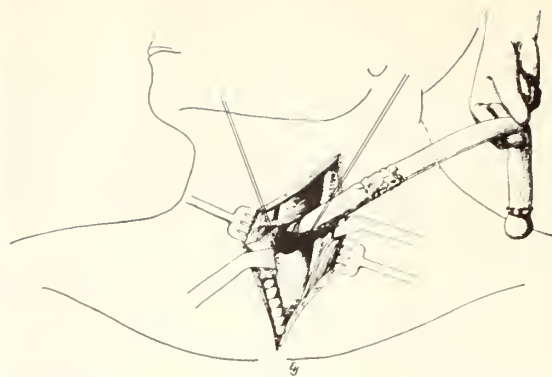


Fig. 2. The stomach is elevated through the superior thoracic inlet and is in position for anastomosis with the pharynx or proximal cervical esophagus.

Generally patients with esophageal obstruction are grossly malnourished and have lost weight. In view of the obstruction it cannot be hoped to give them a preoperative diet that will allow weight gain. The establishment of a gastrostomy provides a means of feeding, but results in considerable delay in the excision of the neoplasm and may limit the amount of stomach available for anastomosis in the definitive part of the procedure. We have generally been content to correct dehydration and to attempt to re-establish the normal circulating blood volume by liberal blood transfusion in the patient's preoperative preparation. Clark et al.⁴ have shown the extent of the deficit in the circulating blood volume that may exist in patients with neoplasms of the gastro-intestinal tract. Blood transfusions of from 1000 to 3000 cc. are usually given before operation. Appropriate studies of the electrolyte and protein content of the blood are made. We have sought the advice of a cardiologist regarding the status of the cardiovascular system of all patients before operation. If quinidine or digitalis is thought to be indicated, it is given. The kidney function has been evaluated by blood urea nitrogen studies and kidney function tests as indicated.

Anesthesia

Ether-oxygen is used as the primary anesthetic agent in all patients. An intratracheal tube is inserted under local anesthesia; the general anesthesia may be induced with sodium pentothal. An ether-oxygen mixture is then given as required throughout the procedure. Mechanical insufflation of the lungs during the operation is of considerable help from the operative standpoint. The lungs are insufflated by use of the Mautz¹⁴ attachment to the regular Heidbrink machine or by the use of the spiro-pulsator de-

signed by Crafoord.⁵ Respiratory movement on the part of the patient is controlled both by the high oxygen content of the blood and by the use of small doses of curare intravenously. By using this method a smooth respiratory cycle can be induced with nearly complete immobilization of all respiratory movements. Blood studies on patients anesthetized by this method have shown that the arterial blood can be kept well oxygenated.

Operative Procedure

The patient is placed on the operating table on the right side and the left seventh rib is resected subperiosteally. A combined abdominothoracic approach may be used if desired. It may be advisable to explore the cervical region before the thoracic incision is made in case it proves impossible to resect the lesion locally (Case 2). A simultaneous exploration of both neck and thorax may be advantageous, although we have not used it. The thoracic esophagus and contiguous nodes are dissected from the mediastinum, the diaphragm is opened, and the stomach mobilized and completely freed of all its attachments with the exception of the right gastric and right epiploic vessels. The left gastric artery is ligated at the celiac axis and the tissue containing the regional nodes remains attached to the esophagus. The duodenum can be mobilized by an in-

cision along its lateral margin to provide additional mobility of the stomach. The esophagus is divided at the esophagogastric junction and the stomach is closed. The esophagus with the contiguous tissue is displaced from behind the arch of the aorta and the dissection is continued into the cervical region through the superior thoracic inlet. We have found it expedient to suture the cut end of the esophagus to the stomach after the esophagus has been transplanted lateral to the aortic arch (Fig. 1). The diaphragm is then closed about the pyloric end of the stomach after it has been placed in the thorax in the highest position possible; the thoracic wound is closed. The patient is then placed on his back and an oblique incision is made along the anterior border of the left sternocleidomastoid muscle. The cervical esophagus is mobilized and the thoracic esophagus is pulled up into the wound through the superior thoracic inlet. Using gentle traction on the esophagus, the fundus of the stomach is then drawn up into the neck. After fixing the stomach to the pre-vertebral fascia with a few interrupted stitches, an anastomosis is made between the stomach and the proximal stump of the esophagus or pharynx (Fig. 2).

Blood Replacement During Operation

Blood lost during operation is estimated by weighing sponges before and after use. This provides an accurate estimate of the amount of blood lost at any period during the operative procedure and permits accurate replacement by blood transfusion during the operation, avoiding any changes in the patient's blood volume. The amount of blood generally lost is between 2000 and 3000 ml.¹⁵

Postoperative Care

The anesthesia is administered so that at the completion of the procedure the patient is responsive. The Levine tube which has been inserted into the stomach is left in place for 48 to 72 hours (Fig. 3). Following removal of the tube the patient is allowed small amounts of water by mouth. Some authors have mentioned the danger of permitting a Levine tube to lie through the site of the anastomosis of the esophagus and stomach, though we have not experienced difficulty from this. There is a definite advantage in avoiding gastric distention in the immediate postoperative period by use of the Levine tube. A liquid diet may be started 72 hours after operation and within five days a soft diet may be taken by mouth. There has been no



Fig. 3. The stomach lying within the thorax shows considerable distention. Gastric suction relieves distention with reduction of strain on the suture lines and permits further expansion of the lung.

difficulty with regurgitation of the food taken, nor have there been symptoms referable to the presence of the stomach within the thoracic cavity. Auricular fibrillation is not an uncommon postoperative complication. Quinidine and digitalis have been used under the guidance of a cardiologist to control such complications when they occurred.

Results

During the past 14 months we have seen six patients with lesions of the esophagus between the pharynx and the arch of the aorta. All patients have been operated upon. In five of them the combined cervical and thoracic resections were done with an anastomosis of the pharynx or cervical esophagus to the stomach. The Wookey type of operation was performed on the sixth patient and this has not been completed.

Case Reports

CASE 1.—A 65-year-old white man was admitted to Jefferson Hospital Aug. 24, 1948, complaining of progressive dysphagia of one year's duration. He had lost 20 pounds or 10 per cent of his normal weight during the year preceding admission. Physical examination and the usual laboratory tests gave no unusual findings. Esophagoscopy revealed an ulcerated stenosing lesion of the esophagus 25 cm. from the upper alveolar process. Biopsy showed squamous cell carcinoma. A barium swallowing function test showed a constricting lesion of the esophagus at the level of the aortic arch through which barium would pass. The patient was thought to be a suitable candidate for surgery and on Sept. 1, 1948, a combined cervical and thoracic approach was made, the lesion was resected, and esophagogastrostomy was accomplished through the cervical incision. Auricular fibrillation occurred the third postoperative day which was controlled by digitalization. A soft diet was given on the fifth postoperative day and he was discharged from the hospital 13 days following operation. He remained asymptomatic for 11 months after operation. At this time hoarseness developed. Follow-up studies showed swallowing function to be normal. There was no evidence of local recurrence of the lesion. He is working at his usual occupation and has eaten a normal diet since the time of his esophageal resection.

CASE 2.—A 55-year-old white man was admitted to the Jefferson Hospital Sept. 20, 1948. He was sent to the hospital for treatment of carcinoma of the rectum. In addition to the symptoms from the rectal growth, he had had progressive dysphagia for six months. He had lost 40 pounds, or 20 per cent of his normal weight, in the preceding year. The only unusual physical finding on admission was the carcinoma of the rectum. The laboratory studies gave no unusual findings. A barium swallowing test showed a constricting annular defect of the esophagus at the level of the clavicles with complete esophageal obstruction (Fig. 4). Esophagoscopy disclosed obstruction at the level of the cricopharyngeus muscle. The esophagoscope could not be passed into

this area and, although six attempts were made, a biopsy could not be obtained. Resection of the obstructing lesion was undertaken. Due to the height and size of the lesion, a cervical incision was made before the thorax was opened. The tumor, subsequently diagnosed as squamous cell carcinoma, was found to be locally resectable.

The usual combined thoraco-cervical resection was then done, the entire esophagus removed (Fig. 5), and a pharyngo-gastrostomy was made through the cervical incision. He ate a soft diet on the fifth postoperative day. A hematoma was evacuated from the midportion of the thoracic wall seven days postoperatively. This required secondary closure and he was discharged from the hospital on the thirty-sixth postoperative day with instructions to return to the hospital for treatment of his rectal neoplasm. Following his discharge he refused to return to the hospital, although he was urged to do so on several occasions. The carcinoma of the rectum became increasingly troublesome and tenesmus developed. The patient's course was progressively downhill and he died nine months after operation. Shortly before his death he had difficulty with dysphagia and it was thought that he might have a local recurrence of his tumor, but he would not return to the hospital for examination.

CASE 3.—A 58-year-old man with severe Parkinson's disease and far-advanced bilateral pulmonary tuberculosis was admitted to Barton Memorial Division of Jefferson Hospital Feb. 24, 1949. He had progressive dysphagia three months before admission. X-ray studies showed a defect in the esophagus above the arch of the aorta. Esophagoscopy examination showed a large tumor mass, a large portion of which was removed



Fig. 4. The type of deformity of esophageal outline shown by a far-advanced carcinoma of the esophagus.

through the esophagoscope for biopsy. This was reported to be squamous cell carcinoma. He was not considered a good operative risk due to the active pulmonary tuberculosis and Parkinson's disease, but in view of the hopeless prognosis without resection the lesion was removed March 16, 1949, through a combined thoraco-cervical approach with an esophagogastric anastomosis through the cervical incision. He had an uneventful postoperative course until the tenth postoperative day when he had difficulty in swallowing. On the twelfth postoperative day a jejunostomy was done for feeding purposes. He continued to have dysphagia and regurgitated material which appeared to contain tissue. It was thought probable that necrosis of the esophagogastric suture line had occurred, although evidence of mediastinitis or pleural infection was never shown. He died on the sixteenth postoperative day. An autopsy was not done, but there was clinical evidence that the suture of stomach and esophagus was not satisfactory in this instance.

CASE 4.—A 60-year-old white man was admitted to the Barton Memorial Division of Jefferson Hospital on April 28, 1949, with a history of progressive dysphagia of one year's duration. There had been a weight loss of 12 pounds during the year preceding his admission to the hospital. He had had bilateral active pulmonary tuberculosis for 13 years previous to admission. X-ray examination showed a filling defect in the thoracic



Fig. 5. A squamous cell carcinoma is situated at the proximal end of the specimen. The entire esophagus is shown.

esophagus at the level of the sternal notch. Endoscopic examination showed an ulcerating lesion in the proximal fourth of the esophagus. The biopsy report was squamous cell carcinoma. In view of the far-advanced pulmonary tuberculosis, the patient was not considered a good operative risk, but since the prognosis was hopeless without operation, a combined cervical and thoracic incision was made and the lesion was resected on May 10, 1949. A cervical esophagogastric anastomosis was made. This patient died two hours following operation. An autopsy was not done. In view of the satisfactory operative course and lack of diagnostic findings immediately following operation, the combined effects of a prolonged anesthesia and the trauma of an extensive operative procedure may have exceeded the resistance of this very ill patient.

CASE 5.—A 69-year-old white woman was admitted to the Jefferson Hospital Oct. 23, 1949, with a chief complaint of progressive dysphagia of seven weeks' duration. She had lost 20 pounds or 16 per cent of her normal weight during the two months preceding her admission to the hospital. Physical examination gave no unusual findings. Routine laboratory studies were within normal limits. Esophagoscopy showed a large nodular tumor mass at the junction of the upper and middle thirds of the esophagus. Fluoroscopic examination of the chest revealed a mass in the right upper mediastinum which pushed the trachea forward. The barium swallowing test disclosed the mass within the esophagus at the level of the aortic arch. It extended from the fourth dorsal to the eighth dorsal vertebra. A biopsy was taken which was reported as anaplastic squamous cell carcinoma of the esophagus. The patient was thought to be a suitable case for operation and a combined cervical-thoracic approach was made on Oct. 31, 1949. A cervical esophagogastrostomy was accomplished. She had an uneventful postoperative course and was discharged from the hospital on her twenty-ninth postoperative day on a normal diet. After the pathologist examined the resected specimen, the histologic diagnosis was changed from anaplastic squamous cell carcinoma to leiomyosarcoma of the esophagus.

Discussion

Cervical esophagogastrostomy may have certain advantages over intrathoracic esophagogastrostomy for lesions at a level requiring a supra-aortic anastomosis. In the cases reported here the stomach could be delivered into the neck through the superior thoracic inlet without removing a segment of the clavicle or first rib. The operative exposure was satisfactory through resection of a single rib and a cervical incision. Satisfactory exposure of the operative fields in the upper part of the abdomen and superior thorax for intrathoracic esophagogastrostomy is usually difficult. Division of multiple ribs posteriorly may allow adequate exposure. The resection of two ribs, usually the ninth and fourth, as originally suggested to us by Dr. John B. Flick⁷ and later

recommended by DeBakey and Ochsner,⁶ offers the best exposure if the procedure is to be confined to the thorax. Both methods add considerably to the trauma of operation, and the anastomosis of stomach and esophagus high in the thorax is more difficult technically than in the cervical incision.

The blood supply of the superior mediastinal esophageal segment is derived from the inferior thyroid vessels alone after transplantation from beneath the arch of the aorta. A decrease in the length of this segment could be expected to improve the esophageal blood supply at the site of anastomosis and reduce the likelihood of necrosis in the superior mediastinal esophageal segment.

Satisfactory cancer surgery requires a block removal of the tissue surrounding the area of the neoplasm as well as the lymphatics and nodes draining the region. The nature of structures adjacent to the esophagus, particularly the superior mediastinal segment, precludes their removal, although contiguous nodes and areolar tissue can be safely excised. When exposure is limited to the thorax alone, transection of the esophagus through an area of proximal extension of the neoplasm is more likely to occur than if a cervical exposure of the esophagus permits division at a greater distance from the growth. The lymphatic drainage of the superior segment of the thoracic esophagus is to the cervical groups of nodes. In using a cervical incision these nodes can be exposed and resected if required.

Summary

Cervical esophagogastric anastomosis permits resection of neoplasms in the superior mediastinal segment of the thoracic esophagus with the immediate re-establishment of the continuity of the oral-intestinal tract. Five cases have been reported showing the practicability of the procedure. The second case demonstrates the feasibility of total esophagectomy for neoplasm with immediate re-establishment of the oral-intestinal tract.

In lesions requiring a supra-aortic esophagogastric anastomosis, the use of a cervical esophagoga-

stric anastomosis would result in a reduction of operative trauma, simplify the technique of anastomosis, improve the blood supply of the esophagus at the site of anastomosis, and more adequately fulfill the requirements of cancer surgery.

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GEM FROM A DISTRICT COUNCILOR'S REPORT

"I do not agree that councilor district meetings should be discontinued, but feel that if interesting enough programs were prepared more members would attend." (See page 862, this issue.)

TOXEMIAS OF PREGNANCY

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THE MATERNAL mortality in Pennsylvania during the past 20 years was reduced from six to seven per thousand to less than one per thousand in 1947.

Toxemia, infections, hemorrhage, and birth trauma, the principal causes of maternal mortality, are yielding to hospitalization, antibiotics and chemotherapy, transfusions, and surgery.

Better training and better understanding of the problems of pregnancy have resulted in a pooling of experiences and the establishment of adequate obstetric setups in hospitals to make available the known and proved methods of therapy and management.

Education of the people as to the value of adequate prenatal care, proper environment for delivery, and diet has helped greatly to improve the condition of mothers to withstand the stress and strain of childbirth and enables them to recognize dangerous symptoms early.

Toxemia of pregnancy is the slowest condition to yield to modern therapy, and still remains a major problem for the obstetrician. Approximately one-fourth of maternal mortality results from toxemia. In the Pennsylvania Department of Health report for 1947, ten major causes of death were listed and toxemia of pregnancy stood highest with 67 in 322 deaths.

A study of the records of the Wilkes-Barre General Hospital from 1938 to 1948 (a ten-year period), as well as a study of current literature, clearly shows that, although not as common as in the past, toxemia is an ever present danger. For every hundred pregnancies, toxemia will develop in about five. It is wise, then, to review some of the methods of management and our application of the known and proved methods of therapy in individual cases of toxemia.

This paper is concerned not so much with research and study of the pathology of the disease

as it is with a study of its management and application of the known principles of therapy—in other words, “the art of medicine” as it applies in toxemia.

Research and study in the clinics in Pennsylvania as well as clinics in other parts of the country have greatly increased our knowledge and given us a better understanding of the sequence of pathologic changes that takes place as the disease progresses to its final stages. These studies have also opened avenues through which we can approach the subject and develop a plan of management that will include all the known factors.

The average physician practicing obstetrics does not see many cases of toxemia on which to build experience. For example, there were 500 cases in the Wilkes-Barre General Hospital from 1938 to 1948. The number of physicians practicing obstetrics in the hospital was 121. If each physician would have had his share of these, there would have been only four cases of toxemia per physician over a ten-year period.

When confronted with the problem of toxemia plus albuminuria, rising blood pressure, and edema, many physicians have resorted to one of the alternate plans suggested by wisdom. They have either called in a consultant or done the best they could with the facilities at hand, or they have referred the case to a physician limiting his practice to or majoring in obstetrics or have sent the patient to a hospital to be treated by its obstetric staff. This has not always resulted satisfactorily to the patient or to the doctor. Indeed, breaks in the continuity of treatment and referrals too late for effective therapy have resulted in a greater part of the mortality in toxemia.

Prenatal care is the largest single factor in the control of toxemia. That fact is well recognized by the physicians and by the people of our state. The main problem during the prenatal stage is checking on the physiology of the pregnancy and the regulation of the patient and her environment at frequent enough intervals to be effective.

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 27, 1949.

TABLE I
LATE TOXEMIAS OF PREGNANCY AT WILKES-BARRE GENERAL HOSPITAL

<i>Year</i>	<i>Total Deliveries</i>	<i>Cases of Toxemia</i>	<i>Incidence</i>	<i>Died of Toxemia</i>	<i>Died Per Cent</i>	<i>Stillborn</i>
1938-39	918	60	6.5	1	1.7	7
1939-40	812	58	7.1	3	5.2	5
1940-41	988	59	5.9	2	3.2	7
1941-42	1,067	62	5.8	2	3.2	2
1942-43	1,006	44	4.4	2	4.5	4
1943-44	1,051	34	3.2	1	2.9	0
1944-45	1,134	29	2.6	2	6.9	2
1945-46	1,145	47	4.1	1	2.1	8
1946-47	1,885	49	2.6	1	2	2
1947-48	1,768	59	3.3	1	1.7	4
Total 10 years ..	11,774	501	4.3	16	3.19	41

Any deviation from the normal is soon discovered and the symptoms can then be properly evaluated.

One of the principal factors on which we plan our therapy is the fact that toxemia is a progressive disease. In individual cases the rate of progression varies from a rapidly fulminating type to a slow process. The longer it lasts the more organs of the body are involved and the more permanent are the destructive changes.

Control of the patient and her environment early in the disease is of paramount importance. Eleven years ago I read a paper before the Section on Obstetrics and Gynecology of this society which in effect was a plea for early hospitalization of toxemia cases. In this paper the statement was made that hospitalizing the toxemia patient in the terminal stages of the disease or in the eclamptic stage did not materially reduce the mortality; that early hospitalization, restoring fluid and electrolyte balance, sedation, and timely termination of pregnancy will save more mothers and babies than any other known procedure. That statement, in my experience, still holds true.

Textbooks on obstetrics still speak of an ambulatory phase in the management of toxemia and recommend hospitalization when the blood pressure reaches a certain height and albuminuria and edema a certain degree. I believe that this and similar statements, in view of our pres-

ent knowledge, need revision. In a progressive disease such as toxemia, control of the patient and her environment and orderly procedure in management are important from the very onset of the disease. Such patients should be hospitalized as soon as symptoms become definite and a diagnosis is made.

Deliveries and patients requiring treatment of obstetric complications gravitate to the hospitals. During the ten-year period of this study the change-over from home deliveries to hospital deliveries has been pretty well completed. In many well-organized and more populous communities, hospital deliveries constitute over 90 per cent of all deliveries. In Wilkes-Barre the change-over has been similar. In 1938 hospital deliveries constituted 62 per cent of all deliveries; in 1947 they constituted 94.4 per cent of all deliveries.

Obstetrics has become an important department in hospitals comparable to medicine and surgery, and is usually manned by competent physicians.

Hospitals and communities differ and each hospital group solves the problem of organization to meet the needs of medical practice in its own community. The delivery rooms in hospitals have been set up with elaborate care. They are well arranged, adequately equipped, and the technique prescribed is similar to that of the operating surgical units and is rigidly enforced. The nurseries, too, are usually well arranged, man-

aged by adequate personnel, and have a strict technique and procedure.

Organization of the facilities of a hospital and personnel and development of a basic plan or procedure for the management of such serious problems as toxemia merit equal consideration. Hospital authorities and obstetric staffs can do much to aid the physician and his toxemic patient. The provisions and setup for the management of cases of toxemia should be available to all physicians practicing obstetrics in the hospital. The physicians on the other hand should bind themselves to honor such an arrangement.

It has long been an axiom in the profession that delivery of the patient will cure the toxemia. It is in fact the only known way of ending the disease. Yet toxemic patients with their fluid and electrolyte balance markedly disturbed are poor risks for surgery or delivery. The results are equally disastrous to the patient whether delivered by the vaginal route or by cesarean section.

A large part of the treatment and management of toxemia is directed toward the restoration of the fluid and electrolyte balance. Until such balance is restored or marked improvement noted, these patients should not be subjected to any operative or delivery procedures. On the other hand, once improvement is noted, delivery of the patient should not be unduly delayed.

Obtaining a fluid and electrolyte balance does not cure the patient; it merely makes her a better risk for the processes of delivery, whether by vagina or surgery. Delaying the time of delivery or waiting for the natural forces to start the processes of labor after definite improvement has been obtained increases the risks to mother and baby.

The results of present-day management are only palliative and temporary. The disease is progressive and the destructive changes in the body continue. Therefore, the aim is to deliver the patient at the most favorable time for mother and baby.

At its many weekly meetings, the obstetric group of the Wilkes-Barre General Hospital has crystallized a picture of toxemia of pregnancy that can best be expressed in the following theorems:

1. Angiospasm is the basic pathologic condition.
2. Water retention or edema is a cardinal factor.
3. Proteinuria and progressive oliguria are present.
4. There is marked irritability of the nervous system.
5. Toxemia is a progressive disease and if unchecked ends in convulsions or coma and a high mortality.

TABLE II
LATE TOXEMIAS OF PREGNANCY AT WILKES-BARRE GENERAL HOSPITAL

<i>Year</i>	<i>Total Cases of Toxemia</i>	<i>Eclampsia</i>	<i>Pre-eclampsia</i>	<i>Toxemia Superimposed on Hypertension</i>	<i>Toxemia Superimposed on Nephritis</i>
1938-39	60	15	32	4	9
1939-40	58	12	26	10	10
1940-41	59	7	22	15	15
1941-42	62	5	44	3	10
1942-43	44	1	34	0	9
1943-44	34	3	23	4	4
1944-45	29	1	24	1	3
1945-46	47	5	31	7	4
1946-47	49	4	32	2	11
1947-48	59	4	43	5	7
Total 10 years	501	57	311	51	82

6. Toxemia in the early stages is a functional disturbance and, as it progresses, permanent structural changes may occur.
7. Toxemia is terminated by the completion of pregnancy.
8. The resultant injury cannot be evaluated for several months after delivery.

With these concepts in mind, it can readily be seen that there are no short-cuts in the treatment of the disease.

TABLE III

LATE TOXEMIAS OF PREGNANCY AT WILKES-BARRE
GENERAL HOSPITAL

	<i>Number</i>	<i>Died</i>	<i>Per Cent</i>
Eclampsia	57	11	19.3
Preeclampsia and toxemia superimposed .	444	5	1.1
Total number of toxemia cases	501	16	3.19

The obstetric staff formulated the following plan of management for a case of toxemia in the hospital:

1. Adequate prenatal care.
2. Hospitalization as soon as symptoms become definite.
3. Consultation with a fellow practitioner.
4. Isolation of the patient, especially during the acute stage.
5. Specializing the patient by the nursing staff, especially during the acute stage.
6. Eyeground studies by a competent physician.
7. Essential laboratory studies.
8. Measuring fluid intake and output and checking the blood pressure frequently.
9. Having adequate emergency measures near at hand and readily available.
10. Adequate postnatal care.

The obstetric setup for the management of toxemia is based on these concepts:

Consultation requirements are posted for all to see. No physician need fear loss of face by calling in another since the consultation requirement applies to all physicians practicing obstetrics in the hospital including the staff members.

Separate rooms are available for isolation.

An adequate nursing service is made available for specializing the patient.

The nursing service measures the fluid intake and output, takes frequent blood pressure read-

ings, and charts the figures on the proper sheets of the record for the information of the attending physician.

Eyeground studies are usually made by the ophthalmologist.

Oxygen and intravenous trays are made available and kept near at hand as emergency measures.

The laboratory is alerted.

Special sheets are added to the record for the special services, and their use and completion required.

I have said nothing regarding the actual treatment of a case of toxemia. I have merely described the obstetric setup and the personnel put into motion when a case of toxemia in any degree of severity is admitted to the hospital. The actual care and management, the prescribing of medications, the time and method of terminating the pregnancy rest with the attending physician and his consultants.

It stands to reason that the staff is alerted when a serious case of toxemia is in the hospital and that the members will stand by to assist when called upon. This setup is put into motion regardless of the financial resources of the patient or whether she is under the care of a staff member or non-staff member. The attending physician remains the central figure. He is surrounded by adequate facilities, orderly procedure, and has the benefit of the pooled experience of his fellow practitioners. Physicians are made to feel that the setup is their work and that the hospital is their workshop. We have had excellent cooperation from those practicing obstetrics in the hospital.

TABLE IV

DEATHS IN LATE TOXEMIA OF PREGNANCY AT
WILKES-BARRE GENERAL HOSPITAL

8 died within 24 hours—3 died undelivered
2 died within 48 hours—1 died undelivered
6 died after 48 hours

The record of toxemia cases is herewith presented for a period of ten years from 1938 to 1948. This represents the entire war period.

Table I shows the total number of deliveries, the number of toxemia cases, the incidence of toxemia, the mortality, and stillborn. A gradual but definite decline in incidence of the disease can be seen. Apparently war conditions had no effect on the incidence but did have some effect on the mortality of toxemia.

Table II shows the cases of toxemia broken down into the usual types. Diabetes with superimposed toxemia is not shown, since we had only a few cases in the ten-year period and all recovered. This table shows clearly, I believe, that physicians are hospitalizing their patients with toxemia earlier and that the number of late referrals is becoming less.

Table III shows our mortality in the major divisions of toxemia. It is generally known that in multiple pregnancies toxemia tends to develop. Our experience is similar.

Table IV shows the time of death after entry to the hospital.

Wilkes-Barre General Hospital is an open general hospital and invites any reputable physician in the vicinity to practice obstetrics there. Only the indigent maternity patient and the physician's own private patients are under the management of the members of the obstetric staff. Fully 85 per cent of the patients are delivered by the general practitioner.

A total of 121 physicians practice obstetrics in the hospital. They range from a recent licentiate to those who have reached old age. Therefore, their personal experience with cases of toxemia varies widely. At the hospital, however, they have the arrangement based on the accumulated and pooled experience of 500 cases in the past ten years.

Based on the experience of the Wilkes-Barre General Hospital, the following conclusions are presented:

1. Although maternal mortality has been markedly reduced, toxemia of pregnancy is still a major problem and for its control requires the entire obstetric resources of the community.

2. Adequate prenatal care is essential for the prevention or early detection of toxemia.

3. Early recognition of toxemia and early hospitalization for the control of the patient and her environment are necessary to prevent the disastrous results of the disease.

4. Since each physician's experience with toxemia is limited, each hospital group should develop an adequate obstetric setup for the orderly management of the disease based on its pooled experience and knowledge.

5. Termination of pregnancy is the only sure way of ending the disease. However, it should be done only at the most favorable time for the mother and the baby. Pregnancy should not be terminated until the fluid and electrolyte balance is restored or markedly improved.

6. The established procedure for the management of toxemia cases at the Wilkes-Barre General Hospital is delineated in some detail.

7. It is believed that the results and the statistics presented represent a fair sample of the work of physicians in a well-organized community in Pennsylvania.

ABSTRACT OF DISCUSSION

JAMES S. TAYLOR (Altoona): This presentation by Dr. Kocyan clearly demonstrates what can be accomplished in a community or general hospital, not necessarily highly specialized, when a positive plan of action is set up for handling definite entities such as the toxemias of pregnancy confronting the obstetrician, be he a specialist or a general practitioner.

As Dr. Kocyan stated, toxemia of pregnancy in the vast majority of cases is a slowly progressive condition and, if allowed to go untreated or if it is undiagnosed in its early manifestations, will inevitably become a catastrophic condition which may become irreversible just as shock which, if unrecognized or not strenuously treated early, will progress into an irreversible condition. Early recognition, prompt treatment, and preferably early hospitalization are essential, especially if the hospital has seen to it that a plan to properly care for such patients has been set up such as that inaugurated at the Wilkes-Barre General Hospital.

Any hospital which does not adequately man, equip, or support its obstetric department with personnel and measures for prompt, proved, and efficient treatment of the ever threatening obstetric complications is *not* rendering the care to its patients that it should, is *not* responding in full to the confidence that the lay public places in it, and is *not* protecting either itself or the physicians of its community.

Your state society's Commission on Maternal Welfare has preached and urged that all hospitals accepting obstetric patients set up a positive set of consultation rules to be enforced to the full and to have the support of the medical staff, the hospital management and its board of directors. In addition to all toxemia cases, consultation should be required for all cases of obstetric hemorrhage, all cases of labor prolonged more than 24 hours, and all cases requiring cesarean section. This requirement is not to belittle any one physician's efforts, for, as Dr. Kocyan so succinctly put it, "the attending physician remains the central figure" and no physician of any grade of proficiency need "lose face" at any time when making a consultation request for a confrere. Such a request will bring approval from the family, for then they know that you are rendering real service. No one man can be all-sufficient unto himself all the time in all situations. The ready use of consultations in hospital practice is a protection not only to the patient but also to the physician and to the hospital.

Maternal mortality has been reduced in Pennsylvania as well as concurrently all over the United States, but there are still some conditions which must be controlled before any further drop will be realized. The profession has within its grasp *now* the means to further reduce this still uncontrolled portion of maternal deaths.

Some of these deaths are still occurring because the timing of delivery or operation is not proper and because the patient is in no condition to stand further trauma and/or shock. When you encounter a case of true eclampsia with or without convulsions, with uncontrolled hypertension, with anuria or severe proteinuria, with tremendous body edema and possibly the beginning of pulmonary edema, with an elevated temperature, and cyanosis, beginning or far advanced, that patient is *not* a case for immediate delivery per vagina nor by section; *that* patient requires sedation, oxygen, and a chance for her fluid and electrolyte balance to become stabilized. As Stroganoff said years ago, "Stop the fits"; in other words, disregard the baby and get the patient in a condition to withstand any type of delivery by the vaginal or abdominal route.

Strenuous attempts must be made in all cases of eclampsia to bring them into the classification of preeclampsia. Once this has been accomplished, they must be handled as cases of preeclampsia, which may possibly be easier though perhaps less dramatic, and your efforts may be more definitely rewarded. If you fail to reverse the eclampsia status and proceed with a rapid, shocking, or traumatizing delivery or an ill-timed section and lose the patient, and no doubt the fetus, you have a mortality of 100 per cent as far as that lone patient is concerned.

Any physician managing a case of toxemia, even though mild, is playing with fire. Where there is smoke, there must be fire. The smoke-signs of toxemia are proteinuria, little or much; continuous rise of the blood pressure, slow but gradual; edema, slight or great, with continuous over-normal increase in weight; possible headaches, mild or severe, and progressively getting worse; eye symptoms, at first not severe but gradually increasing in constancy. In the vast majority of cases there are weeks, or even months, of these premonitory or warning smoke-signs. Like many material conflagrations this situation may be classified as simply a "flue" fire or it may spread and become an honest-to-goodness four-alarm fire.

Rarely do we see a wholesale real conflagration with-

out it having been a small smouldering fire at its beginning; so also do we rarely see a catastrophic fulminating toxemia without it having given notice by some smoke-sign of having been present for some time previous. No community, large or small, is without its fire department, paid or volunteer; a still alarm may bring sufficient help for complete control if a fire is small, but, on the other hand, it may develop into a four-alarm fire in which teamwork, equipment, training, and experience in fighting fires may be needed. So it is with toxemia in pregnancy; early it may be easily controlled with rest, elimination, sedation, diet, and obtaining fluid and electrolyte balance, but, on the other hand, it may progress in severity and with rapidity, regardless of precautionary and early valiant efforts at control, and terminate in a full-fledged eclampsia. Here and now is where positively, for the happiness of all concerned, you must send out an appeal for help and it is hoped that the hospital in your community has been farsighted enough to set up a program for combating such circumstances. Don't try to fight a four-alarm toxemia with yourself as the lone fireman; call for help and you will be thankful to have had some help to put the fire out. A small fire may become a serious conflagration, so also may a mild toxemia become uncontrollable and progress with rapidity.

Toxemia is a menacing threat to every expectant mother. Only by meticulous ante-partum care, will it be recognized in its early manifestations and enable you to properly evaluate each of the signs and/or symptoms and be in a controlling position in case of a possible catastrophic condition. Toxemia may not be totally eliminated, but the severe, late, convulsive types can be largely prevented by conscientious all-out ante-partum care.

Dr. Kocyan and his co-workers have shown that early recognition, prompt hospitalization, and definite organizational management of toxic cases can reduce the maternal mortality of such patients. They are to be congratulated on their foresight and teamwork, and their results can be duplicated anywhere if only the effort is made.

GI BILL STUDENTS RE-ENTERING SERVICE GIVEN EXTENSION

Veterans who have started GI Bill studies and interrupt them to go back into active military or naval service will not be bound by the July 25, 1951, cut-off date for returning to training, Carl R. Gray, Jr., Veterans Administrator, ruled recently.

Instead, Mr. Gray said, they'll be allowed to resume their training within a "reasonable period" following their release from active service, even though they get out after the deadline date.

Under Mr. Gray's ruling, a veteran will have to meet these three requirements:

1. The conduct and progress in his GI Bill course must have been satisfactory.
2. The amount of training he may obtain after he

gets out of uniform will be limited by his remaining GI Bill entitlement.

3. And his course may not extend beyond the wind-up of the GI Bill program on July 25, 1956.

Under the law, the July 25, 1951, cut-off date applies to World War II veterans discharged before July 25, 1947. For those few discharged afterwards, the cut-off date is four years from date of discharge.

Samuel Gompers, as president of the American Federation of Labor, said: "Look all over the world, where you will, and see those governments where the features of compulsory benevolence have been established, and you will find the initiative taken from the hearts of the people."

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EDITORIALS

AN EXPERIMENT IN INSTRUCTION

Four days of graphically presented instruction reflecting many phases of recent medical progress await the physicians who will attend the 1950 convention of The Medical Society of the State of Pennsylvania in Philadelphia—scientific programs all day Monday, Tuesday, Wednesday, and Thursday.

The innovation in this year's program is to be introduced on Thursday afternoon in the form of intimate study clubs, each presided over by a moderator and two or three instructors experienced and skilled in the field designated on the program, which may be found beginning on page 841 of this issue of the JOURNAL.

This program has been developed by Dr. Paul C. Craig who has more than once on previous occasions demonstrated that he is a past master in arranging for the presentation of study clubs designed to encourage informal discussions of a given topic or problem.

As a result of this type of program, those who attend will find illumination of each subject from many points of view. Dr. Craig says of this form of instruction: "In seven years of experimenting with many forms of instruction, I have found study clubs to be the *most valuable and useful method of teaching.*"

Each of the eight study clubs scheduled for Thursday afternoon, 1:30 to 5:00 p.m., may be

found comfortably ensconced in separate rooms in Convention Hall, 34th Street & Curie Avenue, with the exception of that on dermatology.

It is believed that if each registrant at the convention will familiarize himself with the character and quality of each study club program as planned, he will determine that he cannot afford to miss attendance upon one or more study groups with their brilliant array of talent prepared to give instruction on the several dynamic topics. Turn to this program on page 841 and decide now which of the following subjects will draw your attention:

Problems of the Newborn
The Handicapped Child
Congenital Heart Disease
Arthritis
Diabetes
Heart Disease
Industrial Medicine
School Health Services
Pennsylvania's Public Health Survey
Alcoholism
Headaches
Treatment of the Cerebrovascular Accident
The Proper Selection and Interpretation of Clinical Laboratory Procedures
Premalignant Lesions of Stomach and Colon
Hodgkin's Disease—Roentgen Therapy
Obstetrics
Gynecology
Glaucoma Problems
Common Office Procedures in Otorhinolaryngology

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

The Study Club on Dermatology will take the form of clinics on the "Common Dermatoses," 1:20 p.m. to 5:00 p.m., at the Department of Dermatology, University of Pennsylvania, adjacent to Convention Hall.

After having chosen from this list the subjects likely to interest you most, turn again to the program and satisfy yourself, from the assigned array of moderators and instructors, that you are not likely to be disappointed with the selection of any of the above-mentioned subjects for your participation in our society's brand new study club experiment.

DISPLACED INTRACRANIAL CALCIFICATION IN THE DIAGNOSIS OF BRAIN TUMORS AND OTHER SPACE-OCCUPYING DISEASES

Physiologic calcifications in the pineal and choroid plexuses of the lateral ventricles serve as valuable landmarks in the diagnosis of space-occupying disease. Therefore, it is essential to demonstrate calcific deposits in these structures and determine their positions in routine examinations of the skull. The pineal body is a more valuable landmark than the choroids, because calcium is demonstrated in it more frequently, and it is normally mid-line in position. In approximately 60 per cent of adults, the pineal body contains enough calcium for roentgen visualization. The normal pineal zone has been established, so displacement is readily determined. When the pineal body is outside of its normal zone, a diagnosis of space-occupying disease is warranted. The direction and amount of displacement indicate the approximate site and size of the lesion.

Lateralization of disease is often possible by frontal and occipital projections. A shift of the pineal body from the mid-line amounting to more than $2\frac{1}{2}$ mm. is usually on the basis of a tumor or hematoma.* Rarely is the pineal body on the side of disease unless one cerebral hemisphere is underdeveloped or contracted. Accurate localization of the pineal body depends on exact positioning of the patient (avoiding tilt and rotation of the head) and films of good technical

* Roentgen Demonstration of Displaced Intracranial Physiologic Calcification and Its Significance in the Diagnosis of Brain Tumors and Other Space-Occupying Diseases, *Radiology*, 53: 625-632, November, 1949.

quality. Stereoscopic studies are essential unless the calcium deposit in the pineal body is sufficient to clearly indicate its position by single views. Since it is possible to determine the presence of space-taking disease and localize it on the basis of displaced calcification, it is obvious that an adequate skull study is essential in every patient with symptoms and clinical findings of intracranial disease.

BARTON R. YOUNG, M.D.

COLOR TELEVISION AT ANNUAL SESSION

Medical color television will in a sense be visiting its birthplace in October when it makes its first appearance at an annual session of The Medical Society of the State of Pennsylvania in Convention Hall, Philadelphia, for it was at the State Society's meeting two years ago that the application of this new aid to medical teaching had its genesis.

After seeing a surgical presentation on black-and-white television at that meeting, Dr. I. S. Ravdin, John Rhea Barton professor of surgery at the University of Pennsylvania School of Medicine, suggested to the sponsors, Smith, Kline & French Laboratories, that they investigate color television, which he had seen demonstrated in the research and development laboratories of the Columbia Broadcasting Company.

Dr. Ravdin's point was that the color factor was not merely a novel improvement, but was actually an essential to effective surgical and medical telecasts. You may have seen black-and-white TV demonstrations, in which the operative field frequently appears flat and undefined because it has only monochrome shadings to differentiate the various anatomic landmarks.

The sponsor negotiated with the Columbia Broadcasting System for the manufacture of color television equipment designed especially for hospital use. After a week of testing at the University of Pennsylvania Hospital, color television was formally presented as a medical teaching aid at the AMA annual session in Atlantic City in June, 1949.

Now, two years after the idea was conceived, a color television program presented from the Hospital of the University of Pennsylvania will be a part of the Pennsylvania Medical Society's meeting October 16-18 in Convention Hall.

Experience with this new medium has increased considerably in that time. Eleven presentations have been made at medical meetings throughout the country. A total of 130 medical clinics and 125 surgical operations have been color-televised. Through their sponsorship of this project, SK&F have made a valuable contribution in evolving new techniques of medical teaching, the efficacy of which you may judge at the October demonstration.

The first appraisal of medical color television suggested that its greatest value was in the teaching of surgery. For years surgical teachers have been confronted with the great difficulty of providing students with adequate views of surgical procedures. Films have partly solved this problem, but most surgeons agree that they cannot be as helpful as witnessing the operation itself. The classic surgical amphitheater, so familiar to generations of medical students, has long been recognized as of dubious value, for no one in the audience can obtain a close view. Recently, great improvements in this regard have been made in operating room construction. In many hospitals an observation balcony, built over the operating room, permits, with the aid of binoculars, a fairly adequate view of the operative field by a small number of spectators.

Color television seemed to present the solution to many problems. The camera, which is quite mobile, was moved to within a few feet of the operative field. It transmitted full-color details of the operations, with all the shadings necessary to identify the anatomy. Usually the view on the screen is slightly larger than life-size, but in the case of eye surgery the image is magnified fivefold on the receivers. This view can be transmitted to any convenient location; the size of the audience is limited only by the number of receivers available.

So the medium was viewed with enthusiasm as an ideal way to teach surgery. It has justified this enthusiasm, but at the same time it has assumed equal importance in the teaching of clinical medicine at medical gatherings.

Clinical medicine—as a subject for color television—presents special problems. The first year's experience has demonstrated that the television audience is not bound by the usual feelings of courtesy to a speaker. If they find the subject or its manner of presentation dull, the audience begins to leave at once. This provides a more accurate index than ever before available of the type of material and form of presentation

that is preferred by medical audiences at the graduate level. The subjects selected and their method of presentation must utilize the advantages of the medium in order to be effective. The pictorial content of the presentation is of the utmost importance. For this reason the demonstration of patients, the discussion of new diagnostic or therapeutic techniques using living subjects, the use of simplified graphs and diagrams, the demonstration of gross pathologic specimens, have proved interesting and effective, while a lecture without patients, using over-complicated charts and slides to document points which can be grasped without visual aids, has proved almost uniformly unsuccessful. In this respect the television audience is in no sense unique. One merely discovers immediately how they feel about such a presentation.

Two principal applications of color television are now viewed as definite possibilities. First, rather than merely being a novelty at medical meetings, the medium seems destined to assume a permanent place as a teaching aid at these postgraduate sessions. Color television solves the old problem faced by members attending these sessions: how to witness medical clinics scheduled not at the convention site but at a hospital at a distant point in a strange city. With color television, the mountain comes to Mohammed. This was illustrated at the American College of Physicians meetings last spring, as reported in *Annals of Internal Medicine*, June, 1950:

"Televised Clinics in Color. A new feature on the program of the American College of Physicians was the television in color of medical clinics from the Massachusetts General Hospital to the auditorium. The Massachusetts General Hospital was utilized as the source of transmitting the programs, but numerous Boston hospitals presented their cases from this one place. This program proved extremely popular, and the consensus was that it is entirely practical and worth while to televise in color many of the medical clinics. Between 700 and 800 physicians attended the televised clinics daily, and this greatly relieved the pressure of attendance at the hospital clinics. Had it not been for the television program, the capacities at the hospital clinics would have been inadequate to accommodate the members. It is believed that the television program can be further improved and extended in succeeding years, and it is now planned to arrange an even more extensive television program in color at the 1951 annual session."

Second, it now appears probable that color television will eventually be installed in medical schools as a permanent teaching aid. This is contingent upon many factors, technical and

otherwise, but nevertheless remains a potentiality of importance.

A three-day program of varied surgical and medical procedures to be transmitted from the Hospital of the University of Pennsylvania is being planned for the Pennsylvania Medical Society session, and will be listed in next month's issue of the JOURNAL. It will give members of the Society ample opportunity to judge for themselves whether color television is, as the *Journal of the American Medical Association* wrote in July, 1949, "another milestone in the evolution of visual education."

KENDALL A. ELSOM, M.D.

DYNAMIC ORTHOPEDICS IN THE RELIEF OF STATIC STRAIN

In this age of extreme mechanization, with many of the labors of life being assumed by elevator, escalator, and automobile, an extremely common and therefore important group of physical ailments has increased to such a proportion as to demand sympathetic attention and the relief of rational treatment. I refer to the lesions of static strain, due fundamentally to inadequate body musculature.

It is generally agreed that most people do not get sufficient exercise, but it is not generally known that such a situation results in actual symptomatology which drives patients vainly from one doctor to another seeking relief, often to find it only in the advice of some non-medical consultant who sensibly administers corrective exercise. This unfortunate situation results not only in the loss of patient confidence as far as the medical profession is concerned but further leads to direct case referrals of friends of these patients to cultists who believe that diet and exercise will cure any disease, including diabetes, pernicious anemia, tuberculosis of the spine, etc. On the other hand, had the physician first consulted advised corrective exercises, such unfortunate referrals could have been avoided.

It should be quite easy for a physician to understand, anatomically, the source of complaint in a case of static strain. We who are still living wage an endless war against the tenacles of gravity. We oppose this action twenty-four hours a day, when we jump, when we walk, when we sit—yes, even when we lie in slumber. The only dynamic opposition we can offer to the tenuous claws of gravity is our neuromuscular force or

tonus, made more efficient by the leverage of the skeletal system. When the neuromuscular system is adequate, the skeletal system is balanced in good posture automatically and comfortably, the joints are in efficient balance, and the ligamentous structures are at ease. With an adequate muscular system, in the absence of skeletal deformity, there is good posture—and there is no static strain. It is not necessary to be ever mindful of posture, for efficient posture in a strong healthy body is just as physiologic as cardiac rhythm. It is the object of dynamic orthopedics to develop such musculature.

On the other hand, an inadequate musculature initiates a chain of events that produces symptoms of static strain. The skeletal system slumps, especially in the upright posture, permitting flexible deformities such as pes planus, back-knee, knock-knee, lumbar lordosis with protuberant abdomen, round dorsal spine, winging of the scapulae, shoulder sag with brachial traction neuritis, and forward slump of the neck. These deformities, albeit flexible and very easily corrected in the early stages, produce ligamentous stretch—and ligaments under stretch produce *pain*. This single anatomic truth is the basis for the art of Judo, and is also the basis for the joint aching and pain associated with posture faults; ligaments under stretch produce pain. There is, physiologically, a valiant attempt on the part of a weak musculature to protect these aching joints, and the discomfort of muscle fatigue is added to the symptomatology.

This problem of static strain should be relieved under medical supervision. Salicylates, barbiturates, and dexedrine are not specifics, nor do they in themselves produce relief, but they may be used as tools of the medical profession in controlling such cases. When such med-

GEM FROM A DISTRICT COUNCILOR'S REPORT

"As we see it, the one great endeavor, the one immediate and urgent need of organized medicine in the months that are just ahead, is to get out the vote in November. Our education campaign must be carried on with increased fervor and lucidity, but our endeavors will bear no fruit unless we make every effort to have every citizen exercise his precious right of franchise, and have him register his vote for either a nation of freedom or one controlled by a government of centralization of power and quasi dictatorship." (See page 864, this issue.)

ications, plus the ever present heat lamp, constitute the sole medical advice in lesions of static strain, the patient will often seek relief outside the medical profession, his patience completely exhausted by ineffective therapy.

The orthopedist is mechanically best qualified to administer palliative treatment with the use of such properly fitted crutches as arch supports, orthopedic shoe corrections, knee cages, and various types of pelvic and back supports. These crutches, however, are not of curative value, and must be used only with the idea of their future discard.

The efficient ultimate rehabilitation of static strain symptoms depends on the application of proper methods of muscle strengthening. It behooves the profession to learn these principles from those who best know. The principles of progressive resistance exercise for the development of unusual strength were known to the ancient Greeks, Chinese, and Egyptians. These secrets of development were handed down among professional strong men up until the turn of this century when the famous Eugene Sandow and his contemporaries began to publicly disseminate this knowledge in their personal appearances and in their writings. These same principles, which enable normal musculature to become inordinately strong, can be very efficiently applied to strengthen abnormally weak musculature, locally or in a general fashion, by one versed in their administration. Unusual strength is developed in normal muscle only by progressive resistance exercises even though some men are by inheritance larger in stature and greater in strength than others. The development of exceptional strength is invariably due to proper training methods. Weakened muscles will respond to these same training methods judiciously employed.

These exercises can be efficiently applied only by operators of experience. The muscles are called upon to act against gradually increasing resistance in rhythmical repetitions (10 to 20), using certain basic exercises to strengthen the weakened muscles. This concept of utilizing low repetition graduated resistance exercises for corrective therapy was first stated in the medical literature by Dr. Thomas De Lorme in October, 1945, in the *Journal of Bone and Joint Surgery* in his article "Restoration of Muscle Power by Heavy Resistance Exercise." Anyone attempting the rehabilitation of weakened musculature owes it to his patient to familiarize himself inti-

imately with the only method capable of efficiently increasing muscular strength, namely, progressive resistance exercise.

There are many lesions due to muscle weakness and imbalance which will respond, at times miraculously, to strength-producing exercise, especially in combination with medical therapeutic aids, such as arch supports and corsets. The aching in pronated weak feet will rapidly disappear after proper foot and leg exercises are instituted. The aching knees of fat knock-kneed women lose their misery following the development of adequate quadriceps femoris muscles. The nagging low backache due to postural defect and sagging abdomen is gradually replaced by a feeling of power and stamina when back and abdominal development reaches a significant stage. The paresthesia of brachial plexus traction neuritis due simply to sagging shoulders can be banished by strengthening shoulder elevator muscles. Why should a cervical rib or a taut scalenus anticus muscle present throughout one's life first become symptomatic at 40, or 35, or even 25 years of age? Is it not more logical to assume that progressively less efficient muscle tonus is at fault rather than a structural defect present innocently up to that time?

It must be remembered that, in this modern civilization, our muscles lose their efficiency very early in life due to inactivity, and that it becomes the role of dynamic orthopedics to afford relief to sufferers of static strain through the logical medium of progressive resistance exercise rather than through the standard but highly ineffective methods of diathermy and medications.

JOHN T. EALY, M.D.

UNDERNUTRITION

(EDITOR'S NOTE: This is the fifth of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania. Clinicians should be interested in exploring the writer's theme that "appetite and satiety are emotions.")

Undernutrition is frequently defined as the condition in which a body is more than 15 per cent below conventional average standards. Although such a definition has certain practical merits, it fails to give a proper picture of the disorder. If one is to appreciate the significance of the term, it will be helpful to recall that the human body is in a state of dynamic equilibrium both with reference to mass and to the energy content of that mass. In other words, the body

is in a constant state of flux. It has a certain average stability but in reality it is composed of the temporary transient surpluses of intake over output of materials. Substances are incessantly introduced into the body; they undergo complicated metabolic reactions which are regulated by the endocrine system; other substances constantly leave the body.

With such a concept of the body, undernutrition becomes a much more vital and fascinating condition. First of all, there is what might be regarded as acute or active undernutrition. Here the intake or supply of material fails to keep pace with the loss. Obviously then, this is a phase of observable weight loss which is readily definable as undernutrition. There is, however, another variety of undernutrition of a less dramatic but more chronic type. In such persons, there is for all intents and purposes an equilibrium between intake and output factors, but at a very low level of exchange. In most of these persons the average weight is below normal as a result of preceding or intermittent episodes of acute undernutrition, but it is not rare to have special types of chronic undernutrition with average or even excessive body weights. It is thus most difficult to provide a simple definition. Standards of the optimum levels of intake and output of the several body constituents are lacking. Furthermore, the body has tremendous capacities for adaptation to general and specific failures of supply. When these failures of supply go beyond the ability of the body to adapt itself, physiologic stresses may then develop which result in symptoms. The general picture of undernutrition may be clear, but all varieties of opinion exist as to clinical and subclinical types. One feature, however, is common to all—supply is low in relation to need.

The varieties of undernutrition are many, but a certain order can be developed by consideration of what is lacking. Food essentials are traditionally arranged in six groups: calories, carbohydrates, protein, fat, minerals including gas and water, and vitamins. Clearly then, the failure to supply adequate quantities of the several items in each group would result in special varieties of undernutrition. This fact has been well demonstrated in laboratory studies with special food mixtures. Many highly specific types of undernutrition have been thus produced as, for example, is well illustrated in the voluminous literature on vitamins. However, patients as a rule tend to eat ordinary foods in a great variety

of mixtures. As a result, pure types of undernutrition as seen in the laboratory rarely occur in practice. When undernutrition develops in a patient to the extent that it is clinically important, it is a multiple deficiency problem. It should not be assumed that there are no "common" types. Perhaps the most important common deficiency is inadequate protein, with low calories a close second. There is an old saying that any general diet which is adequate in protein and calories will be adequate in other factors. Perhaps the reverse is also nearly true; a diet low in protein and calories is likely to be deficient in other respects also.

Before the treatment of undernutrition can be discussed, it becomes important to learn why people are undernourished. In acute undernutrition it is usually fairly obvious. Starvation phenomena follow when the intake drops sharply below the output. The intake may stay at a reasonably adequate level, but the output may be greatly elevated as in febrile states. Likewise, in certain metabolic or endocrine disorders, wastage of food may result in a great excess of output over normal or even elevated intake. On the other hand, the less dramatic chronic states, although sometimes rather obvious, frequently require definite analysis. The many contributing factors may be grouped under three headings: (1) "can't get it," (2) "can't eat it," and (3) "can't digest and absorb it."

The "can't get it" group includes the reasons why proper food does not appear on the patient's plate. Many examples will occur to all, but two merit special mention: (1) economic factors and (2) special diets. Good food and especially protein food is expensive. This is a particularly difficult truism for the large body of persons doomed to eat in public restaurants. The special diet field is a great contributor to undernutrition. It is easy to point the finger at the inadequacies of many highly publicized dietary fads; however, it should be noted that frequently a diet intake which is prescribed to care for some specific disorder is grossly inadequate in other respects and may result in serious malnutrition if the patient happens to be loyal to his physician.

The "can't eat it" group includes the reasons why a person cannot get his food from his plate into his stomach. Simple and obvious causes which occur in every practice include the obstructions such as stricture and cancer, the rigid jaws of the arthritic, the sore mouth foul with dental wrecks. Bad cooking is of sufficient fre-

quency to merit particular mention. However, the largest group of causes in the whole field of malnutrition is what may be called the "N-P" or neuropsychiatric states. To be sure, a broad definition of this term is employed but we may logically step from the minor grades of bad habits, such as haste and poor time schedules, to fatigue states, to mild tension states where food odors or associations become important, to more serious anxiety states where intakes may become bizarre, to the extreme of anorexia nervosa. Appetite and satiety are emotions and are very sensitive to extraneous influences. The serious grades of these disorders are by no means common, but the minor grades which are usually dismissed as "bad habits" are the commonest causes of important malnutrition today.

The "can't digest and absorb it" group includes rather obvious mechanical, chemical, and disease states. However, in this group, too, neurogenic factors may be important in conditions such as peptic ulcer or ulcerative colitis, for example.

The treatment of malnutrition should be simple if we know what is lacking and why it is lacking. It is a relatively easy matter to write a diet prescription in which a proper distribution of foods is described and in which the quantities of foods are determined by the rate of change which is desired. Too often the art of dietetics is neglected. The potentialities of ordinary foods should be kept in mind as well as the values of attractive menus. Correction of the cause of the deficiency—the "why"—is sometimes very difficult. If the problem is economic or social, that fact should be recognized and given due emphasis. If the problem is in the sphere of traditional medicine, appropriate steps may be taken. The personality problems may require psychotherapy at all levels of intensity, but the vast majority of patients can be helped by encouragement and instruction in proper habits. For the average case,

a proper manner of life with three meals well planned, well cooked, and served in a pleasant environment and eaten without fatigue, haste, or tension performs a miracle. Proper eating habits and reduced emotional tension will cure most patients.

Undernutrition should be regarded for what it is—a failure of supply to meet the needs of the body. It is not always inevitable even in many serious disorders. On the other hand, it is not always desirable to try to correct mild degrees of undernutrition. What is important is that the physician should not be deceived as to why a patient is undernourished, what can or should be done about it and, if he fails, why he fails.

JAMES M. STRANG, M.D.

KEYSTONES OF PUBLIC HEALTH FOR PENNSYLVANIA

Nutrition

(EDITOR'S NOTE: This is the eighth of a series of guest editorials planned to be constructively critical at times of administrative efforts in public health in the Keystone State. The 1948 Survey to which these editorials are devoted was requested by the 1947 House of Delegates of The Medical Society of the State of Pennsylvania, approved by Governor Duff and Secretary of Health Vaux, and conducted by representatives of the American Public Health Association in the interest of the health of the people of Pennsylvania.)

In this period of advanced medical information resulting from postgraduate courses for the general practitioner of medicine, it is essential that kindergarten, public and private schools, medical schools, the medical profession, and public health physicians should both recognize and stress that the foundation stone of our present and future population's health depends upon nutrition.

Unfortunately, it has been by-passed in so many fields that food faddists appeared and now we have the cure-all vitamin fad. In fairness to all classes mentioned above, one must not lose sight of the fact that many people insist on selecting their own diet unless they are ill and one is prescribed.

A perusal of the Survey Report on Nutritional Services of the Department of Health of the Commonwealth of Pennsylvania brings out clearly the fact that the division is quite understaffed. The Lancaster work was excellent, but should have some state supervision; so was the research work at the Pennsylvania State College. There must be consultation service with other bureaus, certainly the Welfare Department, but decentralized administration, responsible in the

Technical Exhibit at Philadelphia

Ninety-three commercial firms will be on hand to present the newest equipment, pharmaceuticals, appliances, books, and foods. The exhibitors have contributed much towards the success of this meeting and a visit to each booth is the one way in which you can show your appreciation. The exhibit will be open Monday from 10:00 a. m. to 5:30 p. m., Tuesday and Wednesday from 8:30 a. m. to 5:30 p. m., and Thursday from 8:30 a. m. to 2:00 p. m.

final analysis to the Secretary of Health of the Commonwealth of Pennsylvania for policy, must be established in each county, except Philadelphia and Pittsburgh.

The newer knowledge of nutrition must be presented to our schools and lay groups by trained nutritionists and to the medical students and at county medical society meetings by specialists in that field.

The present division has an excellent staff for a beginning, but it should be augmented. By

working with other agencies, using the reorganization suggested, and continuing the work already undertaken, Pennsylvania could rank with the leaders in this vital field of work—both public and private. Furthermore, an in-service training course should be undertaken as soon as possible.

RUFUS S. REEVES, M.D.,
Director of Department of
Public Health,
City of Philadelphia.

TALES OF TWO COUNTRIES

An interview with a man who consulted the writer in the capacity of a patient recently gave some interesting side lights on the present situation in England. This man is an American whose work has made it necessary for him to live in England for the past 13 years.

His best friend and closest neighbor in England is his doctor, and yet he consulted me before returning to his home, because his doctor is so busy he doesn't like to bother him. I had never met him previously.

"He is seeing eight times as many patients as before the 'Health Scheme' went into effect, examining nobody, just giving everybody a prescription, and killing himself doing it."

"How would you get an examination there such as you have had today?"

"You wouldn't, unless you could find a doctor outside the 'Scheme,' and pay for it. Nobody can afford that, anyhow."

"I understand that most of the laboring people like the new Health Plan."

"They did at first, but they're getting wise. They are complaining about the type of care the really sick ones must put up with, and the 'fumbling' of the government."

"How do things look to you here?"

"Your government is almost as bad as ours, and will soon be just as bad if you don't stop them. I'm glad you doctors are putting up a fight against being taken over. Don't let up though. And if they can't win fair, watch for a sneak play. That's what happened in England. Don't ever think politicians are as honest as you are."

A Glimpse Behind the Iron Curtain

A patient returned recently from two months spent in Czechoslovakia, where his wife and son are living. This man is a naturalized American citizen, but cannot obtain passports for his family to leave Czechoslovakia because they are able-bodied and between the ages of 18 and 55. He eagerly gave me this story:

Every able-bodied person between those ages must work for the State, unless excused for some specific reason, such as a woman raising small children. Since this man left Czechoslovakia, women have replaced men in many positions, such as street-car and bus operators,

porters, elevator operators, waiters, clerks, and some types of heavier jobs. All of the men are employed in productive capacity, in the mines, mills, factories, and shops. Women are also used in the lighter factory jobs when needed.

The people are strictly disciplined and live in constant and mortal fear of the government subordinates and the police. Arrests are made at the slightest pretext or on suspicion, and many are never seen again, presumably sent to labor or concentration camps in Russia or Siberia. Large concentration camps are also in Czechoslovakia.

People are taught that nothing belongs to them; they must not speak of my house, my horse, my farm; everything is "ours." (I didn't ask if it is still proper to refer to "my wife.")

This man was arrested eight times in the two months he was there, and with the aid of his American citizenship papers was able to talk his way free every time. He is a smart and forceful talker. He says most of the officials are very "dumb," and he had no great difficulty, posing one time as a "big shot," another as an "inspector," and only in a pinch revealing his true status. He drove his American car over there, and that caused great suspicion and also made a big impression.

In addition to his visa for Czechoslovakia, he had to obtain a permit in each town to leave, had to say where he was going, how long he would stay, what he was going to do, etc. A change in his plans would bring an arrest. Taking pictures of a parade caused one arrest.

He estimates that Czechoslovakia has about 20 per cent of the doctors it had before the war. The rest have fled or have been sent to Russia to take care of the Russians. Those remaining are under complete domination of the government, are worked to death, and are arrested and punished if it is known that they refuse a call. He went to see his old doctor, and found him asleep across his desk, with patients waiting. He had not had his clothes off for three days, and this was his only way to rest.

How long can this sort of thing go on? How long are we going to tolerate people who would connive to bring about the same state of affairs here, or let them off with light sentences for perjury?—*Pittsburgh Medical Bulletin*, June 24, 1950.

SCIENTIFIC PROGRAM

One Hundredth Annual Session

October 16, 17, 18, and 19

Convention Hall, Philadelphia

Monday Morning, October 16

10: 00 a.m. to 12: 00 noon

GENERAL SESSION

BALLROOM, THIRD FLOOR

Symposium on Hepatic Cirrhosis

10: 00 a.m.

The Pathogenesis of Hepatic Cirrhosis.

BALDUIN E. LUCKÉ, Philadelphia.

OUTLINE: The presentation will deal, first, with the modern concept of cirrhosis, and subsequently with the etiologic factors, with the evolution of the disease, and with the functional disturbances which may develop when the process has become sufficiently advanced.

10: 30 a.m.

The Internist's View of the Treatment of Liver Disease.

CHARLES S. DAVIDSON, Boston, Mass. (Guest).

OUTLINE: The most important therapy in the treatment of liver disease, especially in the chronic form, is the provision and consumption by the patient of a nutritious diet adequate in good quality protein. This simple means of therapy has improved the prognosis in liver disease. A nutritious diet contains adequate vitamins, methionine, choline, and other nutrients so that these should not be supplied separately. Fat should not be restricted. When food cannot be taken in sufficient quantity, food complements in as natural a form as possible must be administered. Parenteral feeding with glucose, protein hydrolysates, and vitamins should be used only when sufficient food cannot be taken by mouth, but is as well tolerated in patients with liver disease as those without.

Accumulating ascites and edema can usually be stopped by providing a diet very low in salt. Salt-poor, concentrated human serum albumin administered intravenously is a poor diuretic in most instances and may cause dangerous or even fatal complications.

Bleeding from peptic ulcer or esophageal varices and the occurrence of hepatic coma are the two most serious complications of liver disease at the present time. The internist has little to offer in the treatment of these complications except repeated blood transfusions in the former, and the prevention of infection and the use of oral and parenteral feeding in the latter.

11: 00 a.m.

The Surgical Management of Hepatic Cirrhosis.

ROBERT R. LINTON, Boston, Mass. (Guest).

OUTLINE: One of the new chapters in the relief of hemorrhage from esophageal varices secondary to portal cirrhosis is being written at the present time. It has long been known that the Laennec type of cirrhosis produces an obstruction to the outflow of the portal blood, which results in dilatation of the esophageal veins and frequently hemorrhage. The mortality rate when this occurs runs in the neighborhood of 40 per cent. Although the first portacaval shunt was performed on an experimental animal in 1877, it was not until 1945, when Whipple and Blakemore reported their results, that the operation could be performed on humans relatively safely and with relief of the bleeding from the esophageal varices. At the Massachusetts General Hospital the results, using either splenorenal shunts or direct portal vein to vena cava shunts in approximately 50 patients, have been very encouraging. The mortality rate from the operative procedure has been high, especially in the early cases,

but since with a better selection of them and better preoperative and operative care the results have improved. Among those patients in whom a satisfactory shunt has been performed, no patient has succumbed to hemorrhage and in only a few has post-operative bleeding occurred. The diagnosis, the selection of patients, the operative technique, and the results will be discussed.

11: 30 a.m.

Question and Answer Period.

Monday Afternoon, October 16

1: 20 p.m. to 3: 00 p.m.

GENERAL SESSION

BALLROOM, THIRD FLOOR

Symposium on Antibiotics and Chemotherapeutic Agents

1: 20 p.m.

The Clinical Use of Neomycin—a Preliminary Report.

JOHN R. WOLGAMOT and GARFIELD G. DUNCAN, Philadelphia.

OUTLINE: Neomycin, discovered in 1949 by Waksman and Lechevalier, is produced by a species of *Streptomyces fradiae*. Neomycin is a basic compound readily soluble in water and most active in an alkaline medium. It is thermostable, and is active against a variety of gram-positive and gram-negative organisms. It has considerable activity *in vitro* against *Mycobacterium tuberculosis*, and is active against streptomycin-resistant organisms. Laboratory and clinical studies relative to bacterial sensitivity and resistance, urine and serum levels, excretion, dosage schedule, and toxicity will be discussed. Results of 50 clinical cases treated with neomycin will be presented.

1: 30 p.m.

Aureomycin, Chloramphenicol, and Terramycin.

HARRISON F. FLIPPIN, Philadelphia.

OUTLINE: Aureomycin, chloramphenicol, and terramycin for the most part have a similar spectrum of antibacterial activity, namely, certain virus and rickettsial diseases, both gram-negative and gram-positive bacteria, including penicillin-resistant, streptomycin-resistant, and streptomycin-dependent organisms. However, in certain instances, one agent may prove more effective than another, thus demonstrating the specificity of action of the antibiotics and the importance of an etiologic diagnosis in each case. The development of these newer antibiotics has, to a significant degree, diminished the importance of streptomycin, except in the treatment of tuberculosis. Although there are some grounds for supplanting penicillin by these newer agents as the initial drug in the treatment of infections, nevertheless, penicillin, by virtue of its bactericidal action, remains the most effective drug against the majority of bacterial infections and, since it is least expensive and toxic, it is the drug of choice in the treatment of most of the disease encountered in this part of the world.

1: 50 p.m.

The Role of Antibiotics in the Modern Treatment of Otorhinolaryngologic Conditions.

MATTHEW S. ERSNER, Philadelphia.

OUTLINE: Many otorhinologic infections are amenable to chemotherapy and antibiotic therapy. When antibiotics are prop-

erly administered they will have a bacteriostatic effect upon acute infections. The best results are obtained either by oral or parenteral administration. One must bear in mind that the efficacy of the antibiotics and chemotherapy depends upon the blood level of the drug in the blood stream. These biochemical drugs are of no value where there is localized pus, necrosis of bone, and where irreversible pathologic changes have taken place in the ear, nose, and throat. Local treatment in the form of drops is valueless in chronic irreversible tissue changes. The instillation of drops is of no value where the organisms are resistant to these drugs. One of the great dangers in this therapy is the fact that symptoms very often are masked and one must therefore be on the alert during the régime of antibiotic therapy. Many complications and tragedies have occurred because of the masking of symptoms as a result of antibiotic therapy. Needless to say, however, antibiotics have a prominent place in otorhinolaryngologic therapy.

2:00 p.m.

The Present Role of Antibiotics in the Modern Treatment of Syphilis.

HAROLD R. VOGEL, Pittsburgh.

OUTLINE: Penicillin is the treatment of choice today in the management of the syphilitic. It is far superior to older chemotherapeutic régimes. This superiority is pronounced in the syphilitic pregnant woman and in the newborn. Visceral syphilis, including neurosyphilis, is influenced favorably. The ease of administration, low cost, and relative absence of treatment complications are other factors involved. Treatment schedules are changing and several will be discussed. The management of the patient with syphilis will be discussed as will be the complications of treatment. What can be expected of penicillin in the control of the disease?

2:10 p.m.

The Present Status of Antibiotic and Chemotherapeutic Agents in Surgery.

WILLIAM A. ALTEMEIER, Cincinnati, Ohio (Guest).

OUTLINE: The rapid growth of chemotherapy during the past few years has made it almost impossible for the practicing physician to keep fully informed. More than 184 antimicrobial agents have been described in the literature up until the present time and many hundreds have been under laboratory investigation. Bacitracin, polymyxin, aureomycin, chloromycetin, terramycin, and neomycin are the most promising of the newer antibacterial agents. Each has withstood the preliminary and intensive laboratory investigation and each is now being thoroughly investigated in the clinical management of infections.

Our experimental and clinical studies conducted at the Cincinnati General Hospital indicate that the field of antimicrobial therapy has been extended by these newer agents. An analysis will be given of the results obtained in a variety of surgical infections such as pyogenic lesions, gram-negative bacterial infections, peritonitis, mixed infections of wounds and burns, and a miscellaneous group. In recent years many clinicians have acquired the erroneous belief that there is no longer any problem in the control of surgical infections. Because of the natural variation of bacterial susceptibility, the acquisition of bacterial resistance during treatment with the various antibiotics, and the development of increasing numbers of bacterial strains resistant to the antibacterial agents, the problems in successful management of surgical infections have actually been increased with the development of each new agent. Because of the complexity of efficient modern antibiotic therapy, it is strongly recommended that clinicians have available in local hospitals a good laboratory capable of giving readily and quickly information regarding the types of causative micro-organisms and their susceptibility to the various antibiotic agents both at the start of and during treatment.

3:00 p.m.—Intermission to View Exhibits

3:20 p.m. to 5:00 p.m.

GENERAL SESSION

BALLROOM, THIRD FLOOR

Symposium on Peripheral Vascular Diseases

3:20 p.m.

The Vasodilatation Test in Diagnosis of Peripheral Arterial Disease.

HUGH MONTGOMERY, Philadelphia.

OUTLINE: The blood flow through a normal person's extremities varies greatly under different situations. In a digit, flow

varies between 1 and some 100 cc. per 100 cc. of tissue per minute. Because of these variations it may be difficult to distinguish between a normal circulation, arterial occlusion, and abnormal vasomotor tone. The vasodilatation test abolishes vasomotor tone, helps measure vasomotor tone, and in measuring blood flow in the absence of vasomotor tone estimates any reduction in capacity for blood flow. The methods for measuring blood flow and the methods for abolishing vasomotor tone of the extremities will be discussed.

3:35 p.m.

The Use and Abuse of Anticoagulant Drugs.

IRVING S. WRIGHT, New York City (Guest).

OUTLINE: The use of anticoagulant drugs is now firmly established as a very important addition to the treatment of thromboembolic diseases wherever they may occur. The evidence is conclusive that the treatment of thrombophlebitis with anticoagulants will markedly reduce the disability and the death rate in such cases. In the treatment of coronary thrombosis the death rate can be reduced one-third and the complications rate, about three-quarters, by the use of anticoagulant drugs. Their use in patients with auricular fibrillation and multiple embolization is a great advance.

These drugs, however, have certain inherent dangers and complications may arise if their use is not carefully supervised. Many of these complications are the result of mistakes or lack of careful control of the régime. A review of the types of mistakes encountered and their prevention will be presented.

New anticoagulants including tromexan and paritol will be briefly discussed.

4:05 p.m.

Autonomic Surgery in Peripheral Vascular Disease.

STUART N. ROWE, Pittsburgh.

OUTLINE: In a high percentage of patients with disabling peripheral vascular disease some improvement can be obtained by interruption of the appropriate sympathetic nerve fibers. This applies to the cranial vessels as well as to those of the extremities. The technique and hazards of the various injections and operations ordinarily used will be presented briefly, and the results which may be expected in different pathologic entities will be discussed.

4:20 p.m.

The Surgical Treatment of the Postphlebotic Syndrome (Lantern Demonstration).

ROBERT R. LINTON, Boston, Mass. (Guest).

OUTLINE: The postphlebotic syndrome is frequently observed from one to twenty years following a previous attack of deep venous thrombosis of the lower extremity. This condition consists of edema, varicose veins, status dermatitis, and in many instances chronic ulcerations of the lower part of the leg. For many years various attempts have been made to cure this condition, but none have been wholly successful. In recent years, with a better understanding of the pathologic physiology of the venous circulation in the postphlebotic extremity, a new and radical surgical method of treatment has been evolved. This consists of healing the ulcer while the patient is still ambulatory, then subjecting him to an operation which consists of removal of the long and short saphenous veins, interruption of the deep venous circulation at the level of the superficial femoral vein and the popliteal vein, and in addition a ligation of the communicating veins in the lower leg. The technique of this procedure will be described with the use of lantern slides and the results to date will be given. The reasons why lumbar sympathectomy should not be performed in this disease will also be discussed.

Tuesday Morning, October 17

9:00 a.m. to 10:20 a.m.

GENERAL SESSION

BALLROOM, THIRD FLOOR

Symposium on Pulmonary Tuberculosis

9:00 a.m.

Responsibility of the General Practitioner in the Public Health Aspects of Tuberculosis.

C. HOWARD MARCY, Pittsburgh.

OUTLINE: The tuberculosis control program has several components. Integration of the services of the general practitioner,

diagnostic facilities, tuberculosis hospitals, public health agencies and nursing services, educational groups, and financial resources is essential. The general practitioner is one of the most important forces in the over-all program. People look to the family physician for guidance of their physical destinies. To meet this responsibility in the field of tuberculosis the physician must be familiar with the broad public health aspects of the disease and be prepared both to assume leadership in prevention, diagnosis, and treatment and to cooperate with all agencies and groups in the field. If the general practitioner fails to meet his responsibility, the success of the program will be in jeopardy.

9: 10 a.m.

Résumé of Early Diagnosis of Tuberculosis.

EDWARD A. FAVIS, White Haven.

OUTLINE: Ancient, medieval, and modern physicians have adequately described advanced tuberculosis, recognized its ease of diagnosis and that it is most difficult to treat. It was also realized that in its early stages it was not easy to perceive. Early diagnosis in tuberculosis is a subject about which much has been written and spoken; however, there is sufficient excuse and no apology is offered for its repetition since the disease is still a major health problem of the civilized world. Today the statistics of patients admitted to our sanatoria and those found in mass x-ray and case-finding surveys show that advanced tuberculosis predominates. In the absence of a specific cure, education of the public and the medical student in tuberculosis and early diagnosis is of prime and public health importance. Criticism by the patient and the tuberculosis specialist of the general practitioner for delayed diagnosis has been unjust. The family physician is the "keystone" of the tuberculosis problem. There will be a brief discussion of the essential factors of early tuberculosis and a method of examination outlined, using the well-known examination procedures, history, symptoms, physical examination, x-ray, and laboratory tests of tuberculin, blood, and sputum.

9: 25 a.m.

Medical Treatment of Pulmonary Tuberculosis.

JOHN S. PACKARD, Allenwood.

OUTLINE: During the past five years, the treatment of pulmonary tuberculosis has been greatly changed by the widespread use of streptomycin, dihydrostreptomycin, and para-aminosalicylic acid (P.A.S.). Streptomycin has proved most valuable in the exudative, pneumonic, and (recently) cavitory phases, as well as in laryngeal and endobronchial complications and tuberculous enteritis. The use of streptomycin needs care in selection of cases and requires collapse therapy in combination or follow-up with thoracic surgery for lasting results. In collapse therapy, pneumoperitoneum has gained greatly in favor over pneumothorax. The chief disadvantage of streptomycin is that its prolonged use results in the development of resistant strains of tubercle bacilli. This can largely be prevented or delayed by the concomitant use of P.A.S.

9: 40 a.m.

Benefits of Surgery in Pulmonary Tuberculosis.

RICHARD H. OVERHOLT, Boston, Mass. (Guest).

OUTLINE: Three of the greatest contributions of surgery in the rehabilitation of the tuberculous sick will be discussed. These are: providing permanent collapse, excising diseased lung tissue, and decortication of uninvolved lung bound down by constricting membranes. Many patients with pulmonary tuberculosis have partially destroyed lungs. The volume of the remaining uninvolved tissue is smaller than the volume of the thorax. Thoracoplasty corrects this discrepancy. The new smaller chest permits contraction of diseased segments and prevents pathologic emphysema in healthy segments. A method of shifting the position of the thoracic wall safely and effectively in a single stage operation will be discussed. All patients cannot be successfully treated by pulmonary collapse, however. When thoracoplasty has failed to control disease or when its failure can be predicted, removal of diseased segments, lobes, or an entire lung may be indicated. Long-term results will be discussed. The disease in some patients may have been arrested with the aid of pneumothorax, yet they may suffer from low respiratory reserve. When constricting membranes prevent re-expansion of uninvolved lung, decortication may restore function and improve the status of their health.

10: 20 a.m.—Intermission to View Exhibits

10: 40 a.m. to 12: 00 noon

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

10: 40 a.m.

Some Considerations Concerning the Roentgen Diagnosis of Certain Lesions of the Chest (Lantern Demonstration).

EUGENE P. PENDERGRASS, Philadelphia.

OUTLINE: Familiarity with the roentgen appearance of the healthy chest is a prerequisite for anyone who attempts to interpret chest roentgenograms. Unfamiliarity with normal variance and the modifying influence of a faulty technique not infrequently results in misinterpretation with an attendant chain of difficulties.

Within more recent years, improvement in certain technical factors and apparatus, more attention to careful technique in roentgen examination, and improved follow-up examinations, either through the medium of thoracic surgery or postmortem examinations, have directed our attention, first, to certain limitations of the method and, second, to the urgent necessity for the radiologist and clinician to have a broad fundamental knowledge of pathology.

With these two observations in mind, it has seemed important to present some of the studies that have been employed during the past few years and a series of cases that have been diagnostic problems.

10: 55 a.m.

Clinical Aspects of Primary Carcinoma of the Lung.

JOHN B. FLICK and L. DONALD PRUTZMAN, Philadelphia.

OUTLINE: During the past 17 years since the first successful one-stage pneumonectomy was performed, the risk of major pulmonary surgery has been reduced to a level comparable with that of other major surgical procedures. The surgical cure rate for primary carcinoma of the lung remains, in spite of this, distressingly low. A major factor behind this low rate of cure is the sizable percentage of patients with this disease who are beyond the scope of radical surgery at the time they are brought to thoracotomy. A high index of suspicion for this disease with thorough investigation of its early symptoms is at present the only logical approach to the problem of increasing the rate of cure of primary carcinoma of the lung.

11: 05 a.m.

Pathologic Aspects of Primary Carcinoma of the Lung.

A. REYNOLDS CRANE and THOMAS M. McMILLAN, III, Philadelphia.

OUTLINE: There has been a progressive increase in the incidence of primary carcinoma of the lung noted in all parts of the world. Such increase is also evident in the material accumulated at the Pennsylvania Hospital. Distribution among the population will be discussed, and a review of the current concepts of etiology and pathogenesis given. The anatomic distribution, methods of extension, and the pertinent diagnostic methods which may be used for early recognition of the disease will be presented in the hope that their broader use by the medical profession will help to reduce fatalities from this form of cancer.

11: 15 a.m.

The Heart in Infection.

WILLIAM G. LEAMAN, JR., Philadelphia.

OUTLINE: Routine cardiac studies in a variety of acute infectious diseases show involvement of a previously normal heart in a greater percentage of instances than hitherto suspected. While most of these patients recover completely, knowledge of the presence of heart involvement is necessary in formulating a rational plan of treatment, particularly during convalescence. We have found electrocardiographic involvement in practically every known acute illness. However, in this presentation, based on a study of patients observed at the Philadelphia Hospital for Contagious Diseases between 1940 and 1950, the clinical features of the heart in infection will be stressed. The diagnosis of cardiac involvement will be discussed and the treatment of this complication outlined.

11:30 a.m.

Treatment of Rheumatoid Arthritis.

RUSSELL L. CECIL, New York City (Guest).

OUTLINE: Treatment of rheumatoid arthritis is not yet on a satisfactory basis, chiefly because the etiology of the disease is still unknown. Gold therapy is of value, particularly in early cases. The remarkable effect of cortisone and ACTH in producing remissions has been widely confirmed. Unfortunately, the symptoms usually return promptly when hormone therapy is discontinued. Furthermore, cortisone and ACTH are still too expensive for general use. Various substitutes for cortisone and ACTH, such as pregnenolone, are disappointing and in no way comparable to the steroids recommended by Kendall and Hench. Hydroxyl phenyl cinchoninic acid affects the joints favorably, but often upsets the gastro-intestinal tract.

10:40 to 12:00 noon

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

10:40 a.m.

Management of Infections of the Hand.

L. KRAEER FERGUSON, Philadelphia.

OUTLINE: Infective lesions of the hand, paronychia, distal closed space infections, furuncle of the proximal phalanx, tenosynovitis, and fascial space infections will be discussed. A comparison will be made with the management of these infections before and since the use of the antibiotics. Principles of management will be stressed including an understanding of the underlying pathology, the use of splints in the management of hand infections, placement of incisions to avoid subsequent disability, and postoperative physiotherapy.

10:55 a.m.

Present Concepts of the Early Treatment of Burns of the Hand.

PRESTON C. IVERSON, Philadelphia.

OUTLINE: The ultimate deformity of hands due to burns varies with (1) the agent—thermal, electrical, or chemical, (2) the depth and extent of surface involved, and (3) infection, edema, and other complications. The treatment of acute hand burns should have as its ultimate goal the complete and earliest possible return to full function of all joints, and should be individualized so that the necessity for later reconstructive surgery can be eliminated or kept to an irreducible minimum. The present accepted methods of management will be discussed with special reference to primary excision of the burn and immediate resurfacing of the area.

11:10 a.m.

Reconstructive Surgery of the Hand (Lantern Demonstration).

WILLIAM L. WHITE, Pittsburgh.

OUTLINE: The successful rehabilitation of acquired deformities of the hand depends upon a long-range plan. The sequence of procedures must be plotted for each particular problem; however, the usual order is: (1) obtain adequate skin coverage, (2) repair nerve and bone defects, (3) restore joint movement, (4) secure balance of function by means of tendon grafts and tendon transfers, (5) perform joint arthrodesis when needed to add stability and improve muscle balance. Generally, restoration should be reduced to the point of greatest simplicity in the older and more extensive deformities, while lesser deformities can often be completely restored.

11:25 a.m.

Immediate Treatment of Hand Injuries.

SUMNER L. KOCH, Chicago, Ill. (Guest).

OUTLINE: Wise and skillful treatment within a few hours of the injury can save time, expense and, most important, function for the patient with an injured hand. Before tissues have become widely infiltrated with coagulated exudate and before infection develops, fractures can be reduced, injuries of tendons and nerves repaired, and wounds closed with safety. If temporizing measures are carried out and definitive treatment delayed, the likelihood of a successful outcome is definitely diminished.

Tuesday Afternoon, October 17

1:20 p.m. to 3:00 p.m.

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

1:20 p.m.

Organic Heart Disease and Pregnancy.

CHARLES A. LAUBACH, JR., Danville.

OUTLINE: This is a study of heart disease complicating pregnancy as observed in a group of patients seen at this institution in the past 15 years. The obstetric factors have included age of the patient, parity, prenatal weight gain, type of delivery, and anesthetic used. The cardiac status has been evaluated in regard to type of disease, duration, functional capacity, and findings during prenatal period. Follow-up information on most of the patients has been secured pertaining to survival, other pregnancies, and present functional capacity.

1:30 p.m.

Etiology of Rheumatic Fever—a Critical Review.

GRACE S. GREGG and FRANK J. GREGG, Pittsburgh.

OUTLINE: Until recent years, the etiology of rheumatic fever has been a matter of theoretic conjecture only. The relationship between the alpha hemolytic streptococcus and rheumatic fever was forcibly brought to our attention over a span of the past 20 years by Dr. Homer Swift. The regimentation of many young people during World War II gave unusual opportunities for study of the etiology as well as the epidemiology of rheumatic fever. Thus, the relationship between the hemolytic streptococcus and rheumatic fever seemed to be well established. In view of the apparent specificity of certain cortical steroids in this disease within recent months, a review of the etiology and pathogenesis of rheumatic fever in light of this apparent specificity in treatment is imperative at this time, and is largely the subject of this paper.

1:45 p.m.

The Child as a Patient.

J. FRANKLIN ROBINSON, Wilkes-Barre.

OUTLINE: The child grows and develops within a subordinate relationship to parents. He is not an independently functioning entity. The parents must be included actively in treatment procedures which involve a child. Illustrative material will be presented from the child guidance clinical setting which is applicable in pediatric practice.

2:00 p.m.

Emotional Factors in Cardiovascular Disease.

EDWARD WEISS, Philadelphia.

OUTLINE: Emotional factors may disturb the function, but probably not the structure of the normal heart. In organic heart disease, however, a heavy burden of anxiety may precipitate a cardiac breakdown. The diagnosis of heart disease adds further emotional problems. Under such circumstances, that is, organic heart disease plus anxiety, evaluation of the part that each plays is important and often difficult to determine. This is especially true in such problems as hypertension, pain in the chest, and coronary artery disease. In order not to foster invalidism, one must often encourage activity rather than rest and, in so doing, assume a heavy responsibility. Because these cardiovascular diseases carry the danger of sudden death, their management from an emotional standpoint constitutes one of the most difficult problems in clinical medicine.

2:15 p.m.

Headache.

GEORGE A. WOLF, JR., New York City (Guest).

OUTLINE: A description of the pain-sensitive structures of the head will be given. Experimental evidence and illustrative examples of clinical syndromes will be described in their relation to the mechanism of the production of head pain by stimulation of the pain-sensitive structures. The common types of headaches will be presented in terms of their mechanism, with stress upon the ease of differential diagnosis when the mechanism of headache is understood. Management of patients with headache in the broad sense will be considered from the standpoint of the

physician who first sees the patient, and who in addition may have the burden of long-term management. Specific medical and psychologic therapeutic tools will be described.

1: 20 p.m. to 3: 00 p.m.

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

Symposium on Acute Conditions Within the Abdomen

1: 20 p.m.

Roentgen Aids in the Diagnosis of Acute Conditions Within the Abdomen.

PHILIP J. HODES, Philadelphia.

OUTLINE: Properly planned and executed roentgen examination of acute conditions within the abdomen may reveal much of diagnostic importance. Among the conditions that may be recognized, one may include mechanical obstruction, reflex ileus, peritonitis, a ruptured hollow viscus, ruptures of the spleen and liver, retroperitoneal hemorrhage and infections, pancreatitis, calculi in the urinary tract and gallbladder, strangulation, intussusception, mesenteric thrombosis, and unsuspected masses. Because fluoroscopy is done routinely on these patients as part of their examination, occasionally one identifies pulmonary lesions being masked as an abdominal emergency.

The author will review the roentgen manifestations of the conditions mentioned above and will emphasize the manner in which examinations should be directed.

1: 35 p.m.

Acute Pancreatitis.

NORMAN M. WALL, Pottsville.

OUTLINE: Acute pancreatitis is being diagnosed more frequently because of the increase in the index of suspicion for this entity. To maintain this index of suspicion, one must bear in mind significant predisposing causes and diagnostic signs and symptoms. These factors, plus a substantially elevated serum amylase, are practically pathognomonic for the disease. Every undiagnosed case of severe epigastric distress, particularly cases associated with a diseased gallbladder, should have a serum amylase determination. In this way many more cases of acute pancreatitis will be recognized than in the past. Prophylaxis for acute pancreatitis is the prompt removal of a diseased gallbladder.

1: 50 p.m.

Management of Acute Intestinal Obstruction.

HAROLD G. KUEHNER, Pittsburgh.

2: 05 p.m.

Acute Appendicitis and Its Complications.

JONATHAN E. RHOADS, Philadelphia.

OUTLINE: A review of progress in the treatment of appendicitis over the past 30 years will be presented and the causes of the reduction in mortality analyzed as far as possible. The effect of antibiotics on cases selected for conservative treatment (deferred operation) will be considered, as will the indications for removal of the appendix in the presence of an abscess. The danger of late embolism of the pulmonary artery will be emphasized in relation to the time of discharge of patients from the hospital and the possible usefulness of anticoagulants.

2: 20 p.m.

The Effect of Definitive Surgery on the Natural Course of Duodenal Ulcer Disease.

FRANCIS D. MOORE, Boston, Mass. (Guest).

OUTLINE: In this study a group of 997 duodenal ulcer patients have been investigated without regard to the form of treatment used in their care. Approximately 808 of these patients had no definitive surgical operation. The remainder were operated upon by either subtotal gastrectomy or vagotomy. In the group without definitive surgery we find satisfactory results in approximately 50 per cent, but poor results in 35 per cent. In contrast, the group of patients treated by definitive surgery

showed satisfactory results in about 75 per cent and poor results in approximately 12 per cent. Mortality, with or without definitive surgery, is approximately the same. Despite these figures, it is clearly inadvisable to operate upon all duodenal ulcer patients. Much strength is lent to such a conservative attitude by the observation that about 50 per cent of duodenal ulcer patients do well with almost no consistent or intensive therapy. The task, therefore, remains to separate from the large group of duodenal ulcer patients those individuals with "progressive, virulent, duodenal ulcer disease" who will not do well on ordinary conservative forms of management. It is this group of patients who should be operated upon. The diagnostic criteria for selecting this group of progressive duodenal ulcer patients will be discussed in detail.

3: 00 p.m.—Intermission to View Exhibits

3: 20 p.m. to 5: 00 p.m.

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

Clinicopathologic Conference

R. PHILIP CUSTER, Pathologist, Philadelphia.

LUCIEN A. GREGG, Internist, Pittsburgh.

THOMAS M. DURANT, Internist, Philadelphia.

3: 20 p.m. to 5: 00 p.m.

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

3: 20 p.m.

The Physiologic Basis for the Choice of Anesthetic Agents and Methods.

FRANCIS F. FOLDES, Pittsburgh.

OUTLINE: The reaction of the organism to any given anesthetic agent or method is influenced by physiologic states and pathologic conditions. Therefore, in the choice of anesthesia the physiologic, biochemical, and pathologic changes present in the patient should be correlated with the known pharmacologic effects of the agents to be used. Of the physiologic factors, age, body build, and pregnancy are of primary importance. Among the various pathologic conditions, shock, dehydration, circulatory and respiratory disease, metabolic disorders, kidney and liver disease, allergic conditions, and neurologic disorders merit special attention. The order of importance in the choice of anesthesia should be: (1) the safety of the patient, (2) the ease of the surgeon, and (3) the comfort of the patient.

3: 35 p.m.

Recent Trends in the Treatment of Goiter.

HAROLD L. FOSS, Danville.

OUTLINE: With no relatively common disease has there been so frequent and marked changes in therapy as has been the case with goiter and especially toxic goiter. With the advent of the anti-goiter drugs a new era in the therapy of hyperthyroidism began, while more recently radioactive substances, especially iodine, have been extensively advocated. The treatment of nodular goiter, "adenomatous goiter," multiple or single, is largely surgical. The placing of thiouracil, later propyl thiouracil, in the hands of men in general practice has resulted in a certain control of hyperthyroidism. Many cases which formerly reached the surgeon obtain temporary relief from this medication, the patients being sufficiently relieved to indefinitely postpone surgical therapy which is often indicated. The disappointments that have followed the use of radioactive iodine in the treatment of carcinoma challenge us to seek further for a more satisfactory treatment. The problem of differential diagnosis as related to treatment is more important than ever. The borderline case requires careful study and appraisal before therapy, and certainly surgical therapy, is employed; otherwise, many unnecessary thyroidectomies will be performed. The extraordinary advances that tracer substances and other agents have added to our knowledge of the physiology of the thyroid gland have immeasurably aided us in perfecting the therapy of goiter until, at present, curability in all forms (other than certain of the carcinomas) is assured the patient.

3:50 p.m.

The Management of Functional Uterine Bleeding.

PAUL O. KLINGENSMITH, Philadelphia.

OUTLINE: The management of this disorder should be founded on accurate diagnosis. The pitfalls of clinical diagnosis by exclusion will be pointed out, as well as the importance of etiologic diagnosis with a knowledge of the endometrial patterns.

Treatment should be designed to correct physiologic failure. The facets of this approach will be discussed with full attention to hormonal therapy. The therapeutic usefulness of curettage and the place of irradiation and hysterectomy will be discussed.

4:05 p.m.

Multiple Primary Malignancy.

CLAYTON T. BEECHAM and ALFRED S. FRANTZ, Philadelphia.

OUTLINE: An analysis will be made of the cases of multiple primary cancer seen in the Gynecologic Tumor Clinic at Temple University. It is apparent that a patient with one cancer has greater potentialities for developing another. The examining physician having discovered one malignancy should be even more alert in his search for other growths.

4:20 p.m.

The Diagnosis and Treatment of Intrathoracic Tumors.

STUART W. HARRINGTON, Rochester, Minn. (Guest).

OUTLINE: Many different types of tumors occur in the mediastinal region of the thorax. These tumors are benign and malignant, but all should be considered potentially malignant. The early diagnosis of these growths before they have made serious inroads on the patient's general condition has been of great aid in their surgical removal and to the final result. The lack of response of many of these tumors to conservative treatment has encouraged surgical intervention with the view of complete removal of the growth, and the marked advancement in methods of surgical technique has made operative removal a relatively safe procedure. In a series of 205 of various types of malignant and benign intrathoracic tumors which I have treated surgically, there was an operative mortality of approximately 4 per cent.

Wednesday Morning, October 18

9:00 a.m. to 10:20 a.m.

GENERAL SESSION

BALLROOM, THIRD FLOOR

Symposium on Phases in the Management of Malignancy

9:00 a.m.

The Modern Attack on Malignant Disease.

STANLEY P. REIMANN, Philadelphia.

OUTLINE: One of the most important aspects of the present-day attack on malignant disease is the general recognition that it is part of the large problems of growth and development. This being recognized, attack from the research point of view has spread into nearly all scientific disciplines, with information about how things grow, both normally and abnormally, coming in from many sources. Another important recognition is that there are leads in the literature widely scattered but which have been taken as starting points for a general chemical attack.

9:15 a.m.

Metabolyte Antagonists.

RALPH JONES, JR., Philadelphia.

OUTLINE: It has been established that minor modifications of the chemical structure of many molecular types of essential metabolytes will produce compounds which interfere with the utilization of those metabolytes by living cells. Such a compound is called a metabolyte-antagonist. Compounds which will specifically interfere with the utilization of many of the known vitamins and most of the amino acids have been prepared. This concept has provided the synthetic chemist with a logical basis for the synthesis of potentially useful chemotherapeutic agents. Several different metabolyte-antagonists which inhibit the growth of malignant tumors in experimental animals have been prepared, and one group, the "folic acid antagonists," have been

found to exert a beneficial effect on certain types of human malignancy. The folic acid antagonists have a definite though limited place in the management of acute leukemia. Preliminary studies suggest that their effect may be enhanced by the use of cortisone or ACTH. Certain aspects of the use of these agents in human malignancy will be discussed and implications for further research will be considered.

9:30 a.m.

Leukemia and Blood Dyscrasias.

LOWELL A. ERF, Philadelphia.

OUTLINE: About 10 per cent of the 200,000 annual cancer deaths are due to malignant disease of the reticulo-endothelial system and include leukemia, lymphosarcoma, Hodgkin's disease, multiple myeloma, etc. At present, the most promising theory for the cause of malignancy is that of intracellular deficiencies of specific enzymes which presumably are made by the genes. Malignancies probably are curable because rare cases have been known to spontaneously remit completely. Acute leukemias seem to be an over-reproduction of precursors of leukocytes, while chronic leukemias could be due to the progeny of a single mutant leukocyte. Plasma cell leukemia and eosinophilic leukemia respond to ACTH temporarily. Transfusions are indicated in all leukemias when red cell or platelet, or even white cell levels become markedly decreased. Replacement transfusions are occasionally of temporary benefit. Antibiotics are also indicated to prevent secondary infections. The treatment of lymphosarcoma, follicular lymphoblastoma, multiple myeloma, etc., will be discussed also.

9:45 a.m.

Control of Intractable Pain.

JEROME F. GRUNNAGLE, Pittsburgh.

OUTLINE: This paper will include a résumé of the operative procedures on various parts of the nervous system for the relief of intractable pain. The advantages and disadvantages, as well as the neurologic deficits produced by surgery, will be discussed, also the indications for the various procedures available.

10:00 a.m.

Radioactive Isotopes.

RICHARD H. CHAMBERLAIN, Philadelphia.

OUTLINE: The emissions of radioactive isotopes have proved to be useful in the diagnosis of certain tumors, notably tumors of thyroid gland origin and brain tumors. At the present time the practical clinical application of radioactive isotopes in the treatment of neoplastic disease is largely limited to selected cases of thyroid carcinoma, polycythemia vera, and certain leukemias by means of radioactive iodine and phosphorus. New applications of radioactive cobalt and radioactive gold are being explored. Further advances in the biochemistry of cancer may greatly enhance the therapeutic as well as diagnostic possibilities in the use of these agents.

10:20 a.m.—Intermission to View Exhibits

10:40 a.m. to 12:00 noon

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

10:40 a.m.

The Management of Fever of Unknown Origin.

HOBART A. REIMANN, Philadelphia.

OUTLINE: In all cases of fever, every effort must be made to make an etiologic diagnosis. Fever is usually associated with infection, but may be present in numerous other conditions such as neoplasms, lymphomas, endocrine disturbances, neuroses, and malingering. Besides, there is a small proportion of persons whose temperature is normally somewhat higher than 98.6 F., and in certain women the temperature may rise over 98.6 in the latter half of the intermenstrual period. Rare instances of periodic fever also occur. It is important to determine when temperature over 98.6 F. is an indication of disease requiring treatment or is normal for the case at hand in order to prevent unnecessary diagnostic procedures and therapy.

10:55 a.m.

Diagnosis and Treatment of Allergic Rhinitis.

MALCOLM W. MILLER, Philadelphia.

OUTLINE: Allergic rhinitis, including the seasonal and non-seasonal forms, appears to be the most common form of respir-

atory allergy. The non-seasonal type, in particular, may be relatively mild and long unrecognized or neglected. The fact remains, however, that such non-seasonal allergic coryza is often a prelude to asthma, a much more distressing and disabling development. It is therefore of paramount importance that this threat of potential asthma should be heeded and active steps taken to prevent, if possible, or to lessen the further spread of the sensitization process to the bronchial tract. These observations emphasize the importance of early recognition, specific diagnosis, and adequate therapy of this type of nasal allergy.

11: 10 a.m.

A Review of the Therapeutic Application of Antihistaminics.

GEORGE E. FARRAR, Philadelphia.

OUTLINE: Best results are obtained in hay fever and urticaria. Itching, watery discharge, and sneezing are relieved with less effect on nasal obstruction. Perennial or vasomotor rhinitis and chronic urticaria are less responsive. Only a few asthmatics are relieved by antihistaminic therapy and cough responds better than wheezing. Pruritus and hence secondary infection are relieved in many instances of neurodermatitis and atopic dermatitis. Considering the many pharmacologic actions of this group of drugs in addition to their antihistaminic action, therapeutic usefulness in many diseases is not surprising. The indications, methods of administration, and untoward effects will be reviewed.

11: 25 a.m.

The Case for Histamine as the Basis of Allergic Reactions: Attempts at Its Neutralization.

WILL C. SPAIN, New York City (Guest).

OUTLINE: The importance of histamine as a factor in the anaphylactic response in the lower animal has been established by data gathered by numerous investigators. The importance of histamine as a factor in the sensitization response in man, i.e., in the allergic response, has not as yet been fully shown. In allergic conditions the evidence has been more circumstantial. Direct investigative procedures are difficult. Recent studies to be described have shown, however, the occurrence of histamine, or histamine-like substances, *in vitro* and *in vivo* where specific allergic (human) serum and antigen are involved. Countermeasures against histamine factors in the human have been many, varied, and as a rule, clinically unsuccessful. These will be described. The histamine blocking group of drugs known as the "antihistaminics," successful as countermeasures, will be discussed and their significance evaluated.

10: 40 a.m. to 12: 00 noon

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

10: 40 a.m.

Experimental Attempts at the Relief of Aortic Stenosis.

CHARLES P. BAILEY, ROBERT P. GLOVER, and THOMAS J. E. O'NEILL, Philadelphia.

OUTLINE: This study has been performed upon animals in an effort to explore the various possible methods of overcoming the physiologic difficulties of aortic stenosis. It has taken three forms. The first investigation was of the technical difficulties and effects of punching out a portion of the aortic valve, others by entering the valve through the innominate artery, and others operated upon by entering the valve through the left ventricle. The second approach was an attempt to divide the aortic valve. The third approach was an effort to by-pass the stenotic valve by using a graft of aorta from a donor animal. Since it was necessary to include the aortic valve from the donor animal, the graft was in each instance a two-piece graft. In other dogs the proximal end of the graft was inserted directly through an opening in the left ventricular wall. A summary of our experiences will be presented, with speculation as to the best approach in cases of typical human pathology. Several clinical cases have been treated surgically. The difficulties encountered and the results obtained will be reported.

10: 55 a.m.

The Neurosurgical Treatment of Non-traumatic Intracerebral Hemorrhage Simulating the Common Stroke.

MICHAEL SCOTT, Philadelphia.

OUTLINE: The high mortality in spontaneous intracranial hemorrhage has led most physicians to consider this condition

hopeless. The purpose of this paper is to show that many such cases can be saved by prompt diagnosis and surgery. This report deals with 20 patients operated upon by the author. The symptoms, etiology, and anatomic location of the hemorrhage will be described. The value of such diagnostic aids as spinal puncture, pineal shift, and cerebral arteriography will be reviewed, and the indication for operation and the surgical technique will be outlined. The end results of the above-mentioned group of cases will be presented.

11: 05 a.m.

The Rehabilitation Rate in Bronchiectasis.

GEORGE P. ROSEMOND, Philadelphia.

OUTLINE: The operative mortality of lobectomy for bronchiectasis has been so reduced that it compares favorably with other major surgical procedures. Provided the pathology is so localized that only one lobe or a part of a lobe is sacrificed, pulmonary function is so slightly reduced that relatively normal function can be expected. Extensive resection limits function in proportion. The rehabilitation rate depends on the extent and character of the disease process and is influenced by the presence or absence of postoperative complications, especially emphysema. Postoperative function can usually be predicted by careful preoperative evaluation. Our results will be discussed.

11: 20 a.m.

Changing Concepts in the Supportive Therapy of the Surgical Patient.

JAMES D. HARDY, Philadelphia.

OUTLINE: Recent advancements have increased our understanding of the physiologic mechanisms by which the human subject withstands the trauma of anesthesia and operation. The following are some of the fields in which progress has been made: body fluid compartments, normal blood volume, replacement of potassium and other electrolyte deficits, acid-base relationships, the function of the adrenals in postoperative patients, intravenous alimentation, and the management of the anuretic patient. The application of these concepts in the care of a patient submitted to major surgery will be stressed.

11: 30 a.m.

Malignancy of the Stomach and Total Gastrectomy.

FRANK H. LAHEY, Boston, Mass. (Guest).

OUTLINE: This paper will deal with the contention that the present status of surgery for cancer of the stomach is unsatisfactory, that there is little hope in treating malignancy of the stomach, such as is available elsewhere, with x-radiation, radium, or irradiated isotopes, and that therefore the only promise of improving results consists of earlier diagnosis and more radical removal. With that in mind, this discussion will attempt to support the theory that total gastrectomy is more of a cancer operation than subtotal gastrectomy, being a more encouraging way to deal with patients with cancer of the stomach. To support this contention, data dealing with 142 total gastrectomies, of which 130 have been for malignancy, will be submitted, giving results and comparing mortality, five-year survival rate, and morbidity of these cases with subtotal gastrectomy for cancer of the stomach.

Wednesday Afternoon, October 18

1: 20 p.m. to 3: 00 p.m.

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

1: 20 p.m.

Immunization Program in Pediatrics.

FRANCIS T. O'DONNELL, Wilkes-Barre.

OUTLINE: The various procedures used in immunizing children against diphtheria, whooping cough, lockjaw, scarlet fever, and smallpox will be discussed. The opportune age for each procedure, the length of time that immunity lasts, the number of injections, the value of the booster shot, when and how often it should be given, and the psychologic effect of immunizations will be mentioned.

Many physicians are careless and neglectful when it comes to selling inoculations. If we all would be the type of salesmen

we should be, most of these procedures would be performed in the doctor's office where they rightfully belong instead of in public clinics.

Statistics of all the counties of the State will be presented.

1:35 p.m.

Recent Advances in Immunology.

PAUL B. KREITZ, Bethlehem.

OUTLINE: Most of the problems underlying the principles of immunization remain little advanced as compared to the situation of two or three years ago; in some fields, however, new information of significance has appeared. These have been the use of adjuvants for enhancing the effect of an antigen and the use of these antigens earlier than the present schedule calls for. The varying degrees of antibody response to a measurable antigen stimulus are now receiving a more careful scrutiny, particularly in the field of diphtheria immunization. Aside from the problems related to the control of specific diseases, active immunization may be approached from several points of view: combined immunization, choice of immunization routes, antenatal and neonatal immunization. Each of these must be considered by itself and many new significant facts are now available.

1:50 p.m.

Observations on 320 Cases of Acute Anterior Poliomyelitis.

EDITH E. NICHOLLS, Danville.

OUTLINE: From June, 1944, through December, 1949, there were 320 patients with acute anterior poliomyelitis admitted to the Geisinger Memorial Hospital. The number of cases treated each year has gradually increased from 41 in 1944 to 104 in 1949. The incidence of poliomyelitis in the community is increasing. Of the 320 cases, 50 were non-paralytic, 237 had various degrees of paralysis, and 32 were bulbar. There were 19 deaths or a mortality rate of 5.9 per cent. The mortality rate and amount of crippling were lowest in the age group from 5 to 15 years. The degree of paralysis was highest from 15 to 19 years. After 20 years the amount of permanent damage decreased, but the mortality rate rapidly increased.

2:05 p.m.

Physical Medicine in Poliomyelitis.

JESSIE WRIGHT, Pittsburgh.

OUTLINE: The success of treatment of this neuromuscular disability depends partly on other factors, such as hydration, circulation, nutrition, and elimination; psychologic and philosophic guidance of patient, parents, and professional personnel; background of all those caring for the patient; teamwork so that key measures are in effect day and night.

From the first day of illness, one should have in mind the problems related to the patient as an individual with a vision of rehabilitation covering the acute, early and later convalescent stages. We should avoid the word "chronic" with its connotation of residual limitations and wrong emphasis on the state of muscles rather than on the practical activities of daily living which the patient is taught to meet with what facilities he has been able to develop.

The phases of care presented in the paper will be in relation to examination, analysis of function, and physical and occupational therapy, always modified by personal variations and needs of the patient.

2:20 p.m.

Diagnosis and Management of Rheumatic Fever.

FRANCIS F. SCHWENTKER, Baltimore, Md. (Guest).

OUTLINE: It is evident that many cases of rheumatic fever do not follow the typical textbook picture, and present great difficulties in diagnosis. Since an erroneous diagnosis of rheumatic fever should be avoided, it is imperative that great care be taken in evaluating such cases. All of the various major and minor manifestations must be considered and the diagnosis arrived at by an evaluation of the composite picture. Treatment of rheumatic fever is essentially a community problem requiring the use of all facilities available. The psychologic impact of a long-term illness with possible partial invalidism requires special handling. Cortisone, ACTH, and cinchoninic acid are under study as possible helpful medications.

1:20 p.m. to 3:00 p.m.

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

1:20 p.m.

Neurologic Sequelae of Spinal Anesthesia.

ROBERT D. DRIPPS, Philadelphia.

OUTLINE: A series of 5000 patients to whom spinal anesthesia was administered have been followed for a 6 to 18 month period. Results of this study indicate that lumbar puncture alone may be followed by significant, long-term disability. When a local anesthetic is introduced into the subarachnoid space, additional complications can be expected. Fortunately, there are ways of reducing sequelae. Whether they can be eliminated is questionable. Data will be presented to support these statements.

1:35 p.m.

Diagnosis and Non-operative Treatment of Low Back Pain.

JOHN S. DONALDSON, Pittsburgh.

OUTLINE: Patients complaining of back pain without deformity and minimal signs may respond to conservative measures. Heat, massage, and exercises for correction may be sufficient for patients with strain. Those with mild arthritic changes and no deformity and minimal spasm find that a properly fitted support together with physiotherapeutic measures is often adequate. In advanced cases of arthritis or ruptured intervertebral disk with deformity and spasm, hospitalization is necessary, utilizing complete bed rest and physiotherapy until all symptoms have subsided. This is followed by adequate support. Manipulation helps in selected cases. Tolserol and procaine are useful in diagnosis and treatment. All aids in conservative therapy will be discussed in detail.

1:50 p.m.

Herniation of the Lumbar Intervertebral Disk; a Ten-Year Follow-up Study.

FLOYD H. BRAGDON, Pittsburgh.

OUTLINE: A series of over 500 consecutive patients presenting subjective or objective evidence of root compression in the lumbar region have been operated upon for protrusion or rupture of the intervertebral disk. The follow-up study covers a period of one to ten years and includes evaluation of residual complaints and ability to resume their former occupation or activities. A comparison of results in the "compensation group" with the non-compensation group has been made.

2:05 p.m.

The Orthopedic Management of Arthritis.

PAUL C. COLONNA and ROY I. PECK, Philadelphia.

OUTLINE: A combination of medical and orthopedic forces is necessary for the over-all management of chronic arthritis. From strictly the orthopedic point of view there are available both the conservative and operative approaches to this problem. Very early in the course of the disease the prevention of deformity appears and the armamentarium along conservative lines consists of protective splints, traction, and braces which can be often profitably combined with physical therapy of various kinds. In a small percentage of cases, manipulation under anesthesia with or without revision of the soft tissues, for the resistant contractures is very useful in the rehabilitation of the chronic arthritides. In those with more severe disability, a synovectomy, osteotomy, or an arthroplasty are all available for rehabilitation. Preceding and following these measures, muscle re-education exercises are extremely important and the indications and contraindications for both the conservative and operative measures will be discussed in some detail.

2:20 p.m.

Modern Concepts of Endocrinologic Therapy in Pregnancy.

EDWARD G. WATERS, Jersey City, N. J. (Guest).

3:00 p.m.—Intermission to View Exhibits

3:20 p.m. to 5:00 p.m.

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

3:20 p.m.

Home Care for the Convalescent and the Elderly.

RICHARD R. HOFFMAN, Lebanon.

OUTLINE: A review of the literature will be presented. Home care is a plan to bring hospital service into the home for selected cases. The advantages are: (1) It is economical, about one-fourth the cost of hospital care. It encourages a more prudent use of hospital beds. (2) Home care has many inherent features that make it the best care for many types of patients. (3) The doctor-patient relationship is strengthened. (4) An immeasurable advantage is the beneficial psychologic factor of the home on the patient.

3: 35 p.m.

Treatment of Obesity.

JAMES M. STRANG, Pittsburgh.

OUTLINE: Basic physiologic concepts indicate that the body is in a state of dynamic equilibrium in which the daily interchange of both mass and energy is great. Material must constantly be supplied to the body. It must be metabolized and the metabolic processes must be regulated.

Obesity is a problem of supply of material, although regulatory endocrine disorders may coexist. The treatment is to supply all the needs of the body except for calories and to utilize the body fat deposits for necessary calories. There are many practical points to be considered, such as rates of reduction, meals, drug aids, water swings, and personality factors. Types of diet programs which have been used will be discussed, and a review of successes and failures will be offered.

3: 50 p.m.

The Relationship Between the Pathologist and the General Practitioner.

THOMAS W. McCREARY, Rochester.

OUTLINE: Pathology is a positive clinical instrument, as important in prognosis and treatment as it is indispensable in diagnosis. Pathology can no longer be confined to the little back room with its bottles and bunsen burners, but there must be significant coordination between pathology and medicine. The internist should recognize the pathologist as a specialist on equal ground and it is of the utmost importance that the pathologist be well informed on the clinical aspects of all diseases so that he might better consult with and aid the general practitioner in his care of the patient. Today, pathology is a science dealing with living things and conditions. It furnishes a groundwork of knowledge which facilitates early diagnosis of disease in the living and its cure by scientific methods.

4: 05 p.m.

Treatment of Pruritus Ani.

ROBERT F. DICKEY, Danville.

OUTLINE: This paper aims to correlate the multiple primary and elicited etiologic factors of pruritus ani with therapeutic procedures. Careful observation and analysis of the various clinical pictures of this syndrome enable one to choose a rational therapeutic approach. A simplified treatment plan will be discussed in detail.

4: 20 p.m.

Protein Metabolism in Relation to the Nutritional Aspects of Certain Medical Diseases.

HAROLD A. TAGGART, Philadelphia.

OUTLINE: Protein requirements in man are absolute; any lack of one of the essential amino acids in man's food intake inevitably leads to a trend of symptoms and ultimately to death. Methods of detection of protein deficiencies in disease states, the relationship of blood volume to hypoproteinemia, and the connection between fluid balance and nitrogen balance will be discussed. Certain medical diseases produce protein deficiencies; the fallacy of low protein diets in certain diseases and the reasons therefor will be given. Methods of restoring protein imbalance in disease will be illustrated by case reports.

4: 35 p.m.

Aspects of the Nutritional Management of the Seriously Ill.

ALBERT M. LUPTON, Philadelphia.

OUTLINE: With the onset of a serious illness there is frequently an abrupt cessation of normal nutritional intake or a conditioning by the disease resulting in a deficient status. While some nutrients may be dispensed with for relatively long times

or are in adequate stores for the duration of the illness, others will be deficient very quickly. Electrolyte and water lack may be apparent within a few hours; calories, proteins, and carbohydrates may be insufficient within a day, and some water-soluble vitamins within a few days. The physician must make a conscientious appraisal of the depletion and establish a régime of replacement and maintenance of nutritional balance throughout the illness.

3: 20 p.m. to 5: 00 p.m.

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

Clinicopathologic Conference

MORTON McCUTCHEON, Pathologist, Philadelphia.

JOHN H. GIBBON, JR., Surgeon, Philadelphia.

WILLIAM L. ESTES, JR., Surgeon, Bethlehem.

Thursday Morning, October 19

9: 00 a.m. to 10: 20 a.m.

GENERAL SESSION

BALLROOM, THIRD FLOOR

Symposium on Ulcerative Lesions of the Bowel

9: 00 a.m.

Medical Aspects of Chronic Non-specific Ulcerative Colitis.

HENRY L. BOCKUS, Philadelphia.

OUTLINE: This disease continues to constitute a real challenge to the physician and the surgeon. The etiology of chronic, non-specific, ulcerative colitis is not clearly understood, but advances have been made. They will be reviewed. The diagnosis of the ordinary type usually presents no difficulty. The significant clinical features and technical procedures utilized in diagnosis will be discussed. A broad platform of therapy is indicated. The principal features to be emphasized include: (1) prophylaxis or prevention of recurrences; (2) measures directed toward overcoming the local infection and systemic toxemia; (3) management of the commonly associated nutritional deficiency, and a plan for the maintenance of normal nutrition; (4) the value of psychotherapy, and (5) an outline of the more common complications and their treatment. The indications for operation will be discussed.

9: 15 a.m.

Medical Aspects of Regional Ileitis.

BURRILL B. CROHN, New York City (Guest).

OUTLINE: Two forms of regional ileitis which present different therapeutic problems are recognized. The "cicatrizing form" gives the pipe-stem alteration and the "string-sign" in the terminal ileum; the lesion may not advance with time, is easily resected or short-circuited by a surgical procedure which is accompanied with low or no mortality, and gives very satisfactory end results. The "mucous or submucous form" is ill-defined anatomically and may spread rapidly by "skip-lesions" through the small intestine. The extent of the lesion cannot be determined at the operating table and the end results of surgical treatment are disappointing if not poor.

Medical treatment of ileitis is supportive with protein replacement, concentrated protein feedings in the diet, parenteral vitamins, parenteral liver extract, rest and sunshine. Transfusions and plasma are useful. Antibiotics, particularly streptomycin and chloromycetin, are most promising during the febrile periods. The insoluble intestinal sulfa preparations are disappointing. Cortisone and ACTH are still to be evaluated, but are definitely worth a trial since the lesion is a connective tissue granulomatous infiltration.

9: 45 a.m.

Surgical Aspects of Ulcerative Colitis and Regional Enteritis.

RICHARD B. CATTELL, Boston, Mass. (Guest).

10: 20 a.m.—Intermission to View Exhibits

10: 40 a.m. to 12: 00 noon

SECTION ON MEDICINE

BALLROOM, THIRD FLOOR

10: 40 a.m.

The Diagnosis and Treatment of Hypopotassemia.

WILLIAM A. STEIGER, Philadelphia.

OUTLINE: The clinical conditions in which potassium deficits are most commonly found are diabetic acidosis and dehydration due to the loss of gastro-intestinal juices. It is now possible to recognize hypopotassemia by clinical means.

The recognition of hypopotassemia depends on (1) a knowledge of those conditions in which it is likely to occur, (2) recognition of the clinical syndrome of hypopotassemia, (3) use of the electrocardiogram as a qualitative guide to the serum concentration in these cases, and (4) actual chemical determination of the serum level. The indications and contraindications for the administration of potassium will be outlined. Routes of administration and solutions available will be discussed.

10: 50 a.m.

Management of Patients with Intermittent Claudication.

MEYER NAIDE, Philadelphia.

OUTLINE: Intermittent claudication is a difficult symptom to improve, whether it be due to arteriosclerosis, thrombo-angiitis obliterans, or embolism. Whiskey and priscoline are the two commonly used vasodilator drugs. Tetra-ethyl-ammonium chloride is of little value for vasodilatation, but may relieve claudication resulting from ischemic damage to nerves. Sympathectomy is rarely indicated for intermittent claudication alone. Suction and pressure are of value in some patients.

Reducing the walking rate to 90 steps per minute, from the normal of 110 to 120 steps per minute, enables many patients to walk much farther. Care of the feet is important in preventing gangrene in these patients.

11: 00 a.m.

Observations in Penicillin-Treated Cardiovascular Syphilis.

JOSEPH EDEIKEN, MORTIMER S. FALK, WILLIAM T. FORD, and JOHN H. STOKES, Philadelphia.

OUTLINE: One hundred and eleven cases of cardiovascular syphilis were treated with penicillin; 14 cases were in congestive failure. Except for a mild febrile reaction in nine instances, there was no evidence of therapeutic shock, and although sought for, no clear-cut case of therapeutic paradox. Neither angina pectoris nor congestive failure are contraindications to the use of penicillin in cardiovascular syphilis. There is suggestive evidence of favorable results following penicillin treatment in patients without heart failure, and it is our impression that patients in congestive failure, treated with penicillin and measures to combat congestive failure, responded better than those treated without penicillin.

11: 15 a.m.

Use of Radioactive Iodine in Angina Pectoris.

CHARLES C. WOLFERTH, RICHARD H. CHAMBERLAIN, and JOHN MEAD, Philadelphia.

OUTLINE: During the past two years over 30 cases of angina pectoris have been treated with radioactive iodine. The chief criteria for selection are as follows: (1) The diagnosis must be clearly established. (2) The anginal syndrome must have failed to respond satisfactorily to adequate trial of conventional methods of treatment. (3) The uptake of radioactive iodine by the thyroid gland must be within normal limits.

The immediate objective of treatment is to depress the function of the thyroid gland, but not to the point of producing objectionable symptoms of hypothyroidism. Sometimes a second treatment is necessary. Occasionally the first dose may depress thyroid activity to the extent that symptoms of hypothyroidism appear and small doses of desiccated thyroid are necessary. The effects of treatment usually become manifest in six to twelve weeks.

The results of treatment in otherwise intractable angina pectoris have been encouraging. In a few there has been complete relief from seizures. In most other cases, some improvement has resulted. No arrest in the progress of the underlying coronary disease is to be expected.

11: 30 a.m.

Diagnosis and Therapy in Various Forms of Coronary Heart Disease (Lantern Demonstration).

CLAYTON B. ETHRIDGE, Washington, D. C. (Guest).

OUTLINE: Coronary heart disease embraces a group of pathologic conditions, in each of which deficiencies in coronary circulation produce abnormalities of cardiac structure or function. The pre-eminent pathologic cause is coronary arteriosclerosis. Since the etiology and pathogenesis of arteriosclerosis remain obscure, preventive or curative therapy for coronary heart disease is currently not available in the usual case. However, good medical management offers much to mitigate the morbidity and prevent mortality in this group of diseases. Painful coronary syndromes include angina pectoris, "coronary insufficiency," and myocardial infarction. Other complications encountered are acute pulmonary edema, chronic congestive heart failure, thromboembolic phenomena, cardiac arrhythmias, and conduction defects. The discussion will highlight the differential diagnosis and treatment of these several clinical pictures.

10: 40 a.m. to 12: 00 noon

SECTION ON SURGERY

LOBBY ROOM, SECOND FLOOR

10: 40 a.m.

Medical Treatment of Cataract.

ARNO E. TOWN, Philadelphia.

OUTLINE: Endocrine investigations of a group of relatively young patients with cataract reveal that in most cases there is a metabolic disturbance due to endocrine dysfunction which can be attributed as a factor in the etiology of their cataracts. It is felt that all patients with cataract in the presenile group should have a complete metabolic study, and proper therapy should be instigated to aid in a normal body chemistry before any surgery is attempted.

10: 55 a.m.

The Diagnostic and Therapeutic Problems of Acute Large Bowel Obstruction Due to Carcinoma of the Colon.

ALEX W. ULIN, PAUL J. GROTZINGER, CHARLES L. SACKS, and WILLIAM L. MARTIN, Philadelphia.

OUTLINE: An experience with 341 cases of carcinoma of the colon revealed that in 20 per cent acute obstruction was a problem in diagnosis and treatment. These cases will be analyzed in relation to mortality and effective cancer surgery. The diagnostic and therapeutic problems of associated small intestinal distention appeared in over 10 per cent of the obstructed colons. Conservative and surgical decompressive measures for these emergency admissions will be considered. The details of acceptable management of these obstructed cases will be outlined in terms of the eventual ideal cancer resection.

11: 10 a.m.

The Management of Hydronephrosis.

BOLAND HUGHES, Philadelphia.

OUTLINE: Progressive obstruction at the pelvo-ureteral junction results in progressive impairment of renal function through the interplay of two factors: (1) pressure atrophy and (2) ischemic atrophy. If the pelvo-ureteral obstruction is corrected before irreparable renal damage has occurred, the impairment of renal function is reversible.

The symptomatology, pathologic physiology, indications for operation, operative procedures, and postoperative results will be reviewed and discussed.

11: 25 a.m.

The Surgical Treatment of Benign Lesions of the Pancreas.

RICHARD B. CATTELL, Boston, Mass. (Guest).

Thursday Afternoon, October 19

1: 20 p.m. to 5: 00 p.m.

STUDY CLUBS—AN INNOVATION

OBSTETRICS AND GYNECOLOGY—

Lecture Hall, First Floor

OPHTHALMOLOGY AND OTORHINOLARYNGOLOGY—Room 101, First Floor

PEDIATRICS—Lobby Room, Second Floor

NERVOUS AND MENTAL DISEASES— Room 200, Second Floor

PATHOLOGY AND RADIOLOGY— Room 304, Third Floor

PREVENTIVE MEDICINE AND PUBLIC HEALTH—Room 300, Third Floor

GENERAL PRACTICE OF MEDICINE— Ballroom, Third Floor

DERMATOLOGY—University of Pennsylvania Hospital

OBSTETRICS AND GYNECOLOGY

LECTURE HALL, FIRST FLOOR

1: 20 p.m. to 2: 40 p.m.

Gynecology

DAVID B. LUDWIG, Pittsburgh, Moderator

Participants: John B. Montgomery, Philadelphia;
Robert A. Kimbrough, Philadelphia; and Abraham
E. Rakoff, Philadelphia.

Obstetrics

JOSIAH R. EISAMAN, Pittsburgh, Moderator

Participants: Paul A. Bowers, Philadelphia; John C.
Ullery, Philadelphia; and Abraham E. Rakoff,
Philadelphia.

OPHTHALMOLOGY AND OTORHINOLARYNGOLOGY

ROOM 101, FIRST FLOOR

1: 20 p.m. to 2: 50 p.m.

Glaucoma Problems

PAUL C. CRAIG, Reading, Moderator

Participants: Francis H. Adler, Philadelphia; Jay G.
Linn, Pittsburgh; and Harvey E. Thorpe, Pitts-
burgh.

3: 00 p.m. to 4: 30 p.m.

Common Office Procedures in Otorhinolaryngology LEWIS T. BUCKMAN, Wilkes-Barre, Moderator

Participants: Daniel S. DeStio, Pittsburgh; Raymond
E. Jordan, Pittsburgh; and Benjamin H. Shuster,
Philadelphia.

PEDIATRICS

LOBBY ROOM, SECOND FLOOR

1: 20 p.m. to 2: 20 p.m.

The Handicapped Child

JOHN B. BARTRAM, Philadelphia, Moderator

The Deaf Child.

JOSEPH SATALOFF, Philadelphia.

The Cerebral Palsy Child.

MILTON SARSIIK, Philadelphia.

The Blind Child.

HARRY S. WEAVER, JR., Philadelphia.

2: 35 p.m. to 3: 35 p.m.

Congenital Heart Disease

CARL C. FISCHER, Philadelphia, Moderator

Diagnosis in School Children.

JACOB M. CAHAN, Philadelphia.

The Use of Angiocardiography and Catheterization as
Diagnostic Aids.

DANIEL F. DOWNING, Philadelphia.

Recent Advances in Surgical Treatment.

CHARLES P. BAILEY, Philadelphia.

3: 50 p.m. to 4: 50 p.m.

Problems of the Newborn

HORST A. AGERTY, Philadelphia, Moderator

Participants: H. Eugene Hile, Pittsburgh; George M.
Shadle, Pittsburgh; and David B. Coursin, Lan-
caster.

NERVOUS AND MENTAL DISEASES

ROOM 200, SECOND FLOOR

1: 20 p.m. to 2: 15 p.m.

Treatment of the Cerebrovascular Accident

FREDERIC H. LEAVITT, Philadelphia, Moderator

Participants: Louis B. LaPlace, Philadelphia; Helena
E. Riggs, Philadelphia; Max H. Weinberg, Pitts-
burgh; and Sidney J. Sondheim, Reading.

2: 20 p.m. to 3: 15 p.m.

Headaches

JOSEPH C. YASKIN, Philadelphia, Moderator

Participants: Robert H. Trueman, Philadelphia; Ben-
jamin H. Shuster, Philadelphia; and Leon H. Col-
lins, Philadelphia.

3: 20 p.m. to 5: 00 p.m.

Problem Drinking

C. NELSON DAVIS, Malvern, Moderator

State Health Department Program.

NORRIS W. VAUX, Harrisburg.

Psychiatry.

BALDWIN L. KEYES, Philadelphia.

Internal Medicine.

HAROLD F. ROBERTSON, Philadelphia.

Industry.

GEORGE H. GEHRMANN, Wilmington, Del.
General Practitioner.

JOHN J. SCHOFF, Philadelphia.
General Practitioner.

H. THOMAS MCGUIRE, New Castle, Del.

PATHOLOGY AND RADIOLOGY

ROOM 304, THIRD FLOOR

1: 20 p.m. to 2: 20 p.m.

The Proper Selection and Interpretation of Clinical
Laboratory Procedures

2: 35 p.m. to 3: 35 p.m.

Premalignant Lesions of Stomach and Colon

ROBERT P. BARDEN, Philadelphia, Moderator

Participants: Robert C. Horn, Jr., Philadelphia; Jonathan E. Rhoads, Philadelphia; and Kendall A. Elsom, Philadelphia.

3: 50 p.m. to 4: 50 p.m.

Hodgkin's Disease—Study Club on Roentgen Therapy

Participants: Max M. Strumia, Bryn Mawr; W. Edward Chamberlain, Philadelphia; Frederick G. Medinger, Philadelphia; and Theodore P. Eberhard, Philadelphia.

PREVENTIVE MEDICINE AND PUBLIC HEALTH

ROOM 300, THIRD FLOOR

1: 20 p.m. to 2: 20 p.m.

Industrial Medicine

CHARLES-FRANCIS LONG, Philadelphia, Moderator

2: 35 p.m. to 3: 35 p.m.

School Health Services

HUBLEY R. OWEN, Philadelphia, Moderator

Participants: Ruth H. Weaver, Philadelphia; Sara R. Reeder, R.N., Philadelphia; J. Hart Toland, Philadelphia; and Ralph C. Lanciano, Philadelphia.

3: 50 p.m. to 4: 50 p.m.

Pennsylvania Public Health Survey

ROSCOE P. KANDLE, Trenton, N. J., Moderator

Participants: Vincent T. Curtin, Scranton; and George S. Klump, Williamsport.

GENERAL PRACTICE OF MEDICINE

BALLROOM, THIRD FLOOR

1: 20 p.m. to 2: 20 p.m.

Heart Disease

THOMAS M. DURANT, Philadelphia, Moderator
Congestive Heart Failure.

ROBERT B. NYE, Philadelphia.

Cardiac Arrhythmias.

WILLIAM D. STROUD, Philadelphia.
Coronary Artery Disease.

WILLIAM L. MULLINS, Pittsburgh.
Question and Answer Period.

2: 30 p.m. to 3: 30 p.m.

Diabetes

THADDEUS S. DANOWSKI, Pittsburgh, Moderator
Diet and Insulin.

L. LEWIS PENNOCK, Pittsburgh.
Treatment of Diabetic Emergencies.

BARKLEY BEIDLEMAN, Philadelphia.
Preoperative and Postoperative Care of the Diabetic.

EDWARD L. BORTZ, Philadelphia.
Question and Answer Period.

3: 40 p.m. to 4: 40 p.m.

Arthritis

DOMINIC DONIO, Allentown, Moderator
Diagnosis of Arthritis.

PETER J. WARTER, Trenton, N. J.
Medical Treatment of Arthritis.

HARRY M. MARGOLIS, Pittsburgh.
Orthopedic Management.

PAUL C. COLONNA, Philadelphia.
Question and Answer Period.

DERMATOLOGY

1: 20 p.m. to 5: 00 p.m.

CLINICAL SESSION AT THE DEPARTMENT OF
DERMATOLOGY, 3400 SPRUCE STREET
UNIVERSITY OF PENNSYLVANIA

Representatives from the dermatologic sections of the medical schools in Philadelphia will discuss skin diseases, diagnosis and treatment of cases chosen and presented to meet treatment problems continually confronting the general practitioner.

COLOR TELEVISION

Medical clinics and surgical operations will be televised from the University Hospital directly to Convention Hall during the Annual Session.

Showings will be held Monday, October 15, from 10:00 a.m. to 12:00 noon and from 1:00 p.m. to 3:00 p.m.; and on Tuesday and Wednesday, October 16 and 17, from 8:30 a.m. to 10:30 a.m. and from 1:00 to 3:00 p.m.

A New Program of Graduate Education

The Commission on Graduate Education has announced the first-year program of a new five-year series of special courses.

During the past three years, a general program has been presented with emphasis on bringing the general practitioner up to date. To the best of our knowledge, that program fulfilled its purpose, but it was criticized because it did not permit sufficient time for detailed consideration of subject material.

Realizing that this criticism was valid, but also keeping in mind that any new program must appeal to the general practitioner, the commission has evolved a plan whereby twenty special courses of fifteen hours each will be presented in each of ten centers. This will be done over a period of five years, with four courses being presented in each center each year. Two will be given in the fall and two in the spring.

Details of this program are set forth in a brochure mailed to the entire membership on May 1, 1950. Courses begin the first week in October, and registrations may be made at any time.

If you desire to register, complete the application blank below and mail it with your fee to the Commission on Graduate Education.

FOURTH ANNUAL GRADUATE EDUCATION INSTITUTE

COMMISSION ON GRADUATE EDUCATION

230 State Street

Harrisburg, Pa.

- ☐ Please enroll me for the entire 1950-51 program of the Graduate Education Institute at the center indicated. (Fee \$25.00)
- ☐ Please enroll me for the fall sessions 1950 at the center indicated. (Fee \$15.00)
- ☐ Please enroll me for the spring sessions 1951 at the center indicated. (Fee \$15.00)

Name
(Last) (First) (M.I.)

Street and Number

City and County

Enclosed please find check for as my registration fee.

Make checks payable to The Medical Society of the State of Pennsylvania.

Signed

Check the center you will attend

☐ Allentown

☐ Johnstown

☐ Meadville

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☐ Clearfield

☐ Lancaster

☐ Reading

☐ Wilkes-Barre

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One Hundredth Annual Session

PHILADELPHIA, OCTOBER 15, 16, 17, 18, 19

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PENN SHERRATON, Chestnut at 39th Street	4.00 up	6.50 up	7.00 up
BENJAMIN FRANKLIN, Chestnut at 9th Street	5.00 up	7.50 up	9.00 up
WARWICK, 17th and Locust Streets	5.00 up	.....	8.00 up
JOHN BARTRAM, Broad and Locust Streets	4.50 up	7.00 up	8.00 up
RITZ-CARLTON, Broad and Walnut Streets	5.50 up	8.00 up	8.00 up
SYLVANIA, Locust off Broad Street	4.50 up	7.50 up	7.50 up
ADELPHIA, 13th at Chestnut Street	4.50 up	7.00 up	8.00 up
ST. JAMES, 13th and Walnut Streets	3.50 up	5.50 up	5.50 up
BARCLAY, Rittenhouse Square, East	5.00 up	8.00 up	8.00 up

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Mail the coupon to hotel selected

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You are requested to reserve the following accommodations during the period of the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania, October 15, 16, 17, 18, and 19, 1950, or for such other period as may be indicated herein.

☐ Single Room with bath

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Arriving at a.m. p.m.

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OFFICIAL TRANSACTIONS

One Hundredth Annual Session

CALL TO 1950 MEETING

The first meeting of the House of Delegates of The Medical Society of the State of Pennsylvania will be called to order in the Clover Room, Bellevue-Stratford Hotel, Philadelphia, Monday, Oct. 16, 1950, at 10 a.m. Subsequent sessions will be held as decided by the House, except the session for the election of officers on Wednesday morning.

Notice relative to parliamentary requirements for consideration of proposed amendments to the Constitution and By-laws was published in the May JOURNAL.

Three Proposed Amendments to Constitution and By-laws

The Board of Trustees of The Medical Society of the State of Pennsylvania respectfully submits the following amendment to the By-laws for consideration and action by the 1950 House of Delegates:

Resolution

WHEREAS, Experience gained in recent years throughout the State has demonstrated from the greatly reduced attendance upon the traditional annual councilor district meetings a lack of membership interest, and

WHEREAS, The planning requires preparation and mailing of 12,000 individual communications, with a resultant total attendance of approximately only 1000 society and auxiliary members, and

WHEREAS, The annual expense, exclusive of employees' time in the office of the secretary-treasurer, approximates \$1,500, and

WHEREAS, Section 9 of Chapter VI of the By-laws amply defines the responsibilities and the duties of each councilor, who is also a trustee, and if adequately discharged may "increase the organizational zeal of the physicians of each councilor district"; therefore be it

Resolved, That the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania request the 1950 House of Delegates to delete from the By-laws Section 4 of Chapter IV, which reads as follows:

SECTION 4.—Each councilor district shall hold one or more district meetings each year for the purpose of increasing acquaintanceship, good fellowship, and organization among the physicians of the district. All physicians residing in the district who are eligible to membership in a component county medical society shall be invited to the meetings.

Section 9 of Chapter VI referred to above as amply defining the duties of the councilors reads as follows:

Each councilor shall be the judicial representative of this Society for his district consisting of certain counties. He shall visit the component societies in his district as least once a year and make a report of such visit at the next meeting of the Board of Trustees and Councilors. It shall be his function to help organize com-

ponent county medical societies where none exist; to inquire into the condition of the profession, and to improve and increase the zeal of component county medical societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. Members of the Board of Trustees and Councilors shall be reimbursed for their travel expenses in attendance at Board meetings, and for any official business of this Society.

The Board of Trustees of The Medical Society of the State of Pennsylvania, in support of a recommendation of a special committee to study the proposal for grievance committees in Pennsylvania, recommends to the 1950 House of Delegates the adoption of an amendment to Section 3 of Chapter IV of the By-laws by adding the words *or by the public* at the end of the fourth sentence.

Section 3 of Chapter IV would then read as follows (words in italics constitute the only amendment):

SECTION 3.—The district censors of each councilor district shall sit under the chairmanship of the councilor of the district who shall not have the right to vote. They shall consider every case of appeal from the decision of a component county medical society by a member who has been censored, suspended, or expelled, provided that the appeal is made within three months after the censure, suspension, or expulsion. They shall report in writing their decision thereon to the county medical society, and also to the trustees and councilors of this Society. They shall consider and dispose of all questions affecting the principles of medical ethics that may be referred to them, either by a component county medical society or by this Society *or by the public*. The decision of the censors in every case must be signed by a majority of the board. Any appeal or judicial question arising in a district comprised of less than three county societies shall be referred directly to the judicial council of this Society.

At the regular meeting of the Lancaster City and County Medical Society held on April 5, 1950, the following resolution was adopted:

Resolution

Be it resolved, That Chapter VII, Section 6, of the By-laws of The Medical Society of the State of Pennsylvania, which now reads:

The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of five members.

It shall be the duty of the committee, after careful con-

sideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor of the House of Delegates. To conform to the requirements of the House of Delegates of the American Medical Association, each nominee must have been a Fellow of the American Medical Association for at least two years prior to his nomination.

be changed to read as follows (words in italics indicate amendment):

SECTION 6.—The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of *three members, one member to be elected by the House of Delegates each year to serve a term of three years. At the 1950 Session, the House of Delegates will elect three of its members to serve on this committee designating one of those elected to serve three years, one to serve two years, and one to serve one year. In case a vacancy occurs between sessions of the House of Delegates, the unexpired term of the member of the committee shall be filled by a special election of the House of Delegates held on the first day of the first session of the House of Delegates immediately following the time the vacancy occurs.*

It shall be the duty of the committee, after careful consideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor of the House of Delegates. To conform to the requirements of the House of Delegates of the American Medical Association, each nominee must have been a Fellow of the American Medical Association for at least two years prior to his nomination.

Among the general officers and others to be elected at this session will be:

A trustee and councilor for the Third Council District, to serve for five years, to succeed Dr. Francis J. Conahan, Bethlehem, who is completing his first term of five years.

A trustee and councilor for the Ninth Council District, to serve for five years, to succeed Dr. Frank A. Lorenzo, Punxsutawney, who is ineligible for re-election, having served two complete terms of five years each.

Five delegates and eleven alternates to the House of Delegates of the American Medical Association, to serve from Jan. 1, 1951, to Dec. 31, 1952.

COMMITTEES OF THE 1950 HOUSE OF DELEGATES

COMMITTEE ON CREDENTIALS

Fred B. Wilson, Beaver, *Chairman*
Dorothy C. Blechschmidt, Philadelphia
Frank J. Corbett, Fayetteville

COMMITTEE ON REPORTS OF OFFICERS

Herman A. Fischer, Wilkes-Barre, *Chairman*
Charles L. Shafer, Kingston

Norman C. Ochsenhirt, Pittsburgh
Joseph A. Parrish, Bellefonte
Myer W. Dashe, Reading

COMMITTEE ON REPORTS OF STANDING COMMITTEES

Russell B. Roth, Erie, *Chairman*
Daniel H. Bee, Indiana
Charles L. Fackler, York
William F. Brennan, Pittsburgh
Joseph J. O'Brien, Scranton

COMMITTEE ON REPORTS OF COMMISSIONS

Joseph J. Toland, Jr., Philadelphia, *Chairman*
William J. Corcoran, Scranton
Dudley P. Walker, Bethlehem
Frank E. Butters, Franklin
Mary B. Davis, New Castle

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Stanley D. Conklin, Sayre, *Chairman*
Wendell B. Gordon, Pittsburgh
J. Van S. Donaldson, Butler
Henry B. Kobler, Philadelphia
Constantine P. Faller, Harrisburg

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Joseph F. Dunn, Chester
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Michael Margolies, Coatesville

COMMITTEE ON HOSPITAL RELATIONS

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William E. Chamberlain, Philadelphia
Willard C. Masonheimer, Allentown
John F. McCullough, Pittsburgh
Milton F. Manning, Beallsville
M. Louise Gloeckner, Conshohocken
Wilfred W. Wilcox, Montoursville

COMMITTEE ON REVISION OF CONSTITUTION AND BY-LAWS

Walter S. Cornell, Philadelphia, *Chairman*
J. Stratton Carpenter, Pottsville
Paul G. Bovard, Tarentum
Jesse G. Fear, Berwick
Willis H. Schimpf, Latrobe
Ex officio: E. Roger Samuel, Lewis T. Buckman,
and Walter F. Donaldson

MEMBERS OF THE 1950 HOUSE OF DELEGATES

(The offset names are the alternates.)

ADAMS

Raymond M. Hale, Jr., *Secretary*
Samuel A. Kirkpatrick, *President*
Roy W. Gifford
Joseph J. Baker

ALLEGHENY

William F. Brennan, *Secretary*
Norman C. Ochsenhirt, *President*

Delegates

(Elected to serve in 1949 and 1950)

Glenn H. Davison	George Leibold
Wendell B. Gordon	John F. McCullough
Frederick M. Jacob	C. L. Palmer
George W. Lang	George C. Schein

(Elected to serve in 1950 and 1951)

Paul G. Bovard	Carl F. Nill
William A. Bradshaw	Norman C. Ochsenhirt
John W. Fredette	John E. Weigel
Harold B. Gardner	John W. Shirer
Theodore R. Helmbold	

Alternates

Joseph B. Anderson	James C. Murdock
James Balph	Joseph A. Soffel
John J. Boucek	David Katz
Edward A. Brethauer	Leo P. Sheedy
Elizabeth R. Childs	James W. Speelman
Leo H. Crip	Oliver E. Turner
Francis X. Straessley	James R. Watson
John S. Donaldson	Carl A. Wirts
Samuel H. Adams	Warren A. Wolf
Andrew J. McAdams	William C. Wycoff
Clarence H. Ingram	Jack Z. Rohm
Karl Zimmerman	John Erving
Charles C. Moore	William McNaugher
Elmer W. Rebbeck	Leigh L. Darsie
Jay G. Linn, Jr.	Harry B. Updegraff
John W. Leech	Harry E. Borus
Charles L. Schmitt	William K. Nealon

ARMSTRONG

Cyrus B. Slease, *Secretary*
Calvin E. Miller, Jr., *President*
Frank H. McNutt
Harry J. Thompson
F. O'Neil Robertson

BEAVER

J. Willard Smith, *Secretary*
William T. Rice, *President*
Fred B. Wilson
Alfred E. Chadwick
Donald W. Gressley
Thomas W. McCreary
John K. Grau
Kenneth M. McPherson

BEDFORD

L. Quentin Myers, *Secretary*
Harry A. Shimer, *President*

BERKS

Clair G. Spangler, *Secretary*
Matthew J. Boland, *President*
William J. Goetz
Harold A. Strunk
Jeremiah B. Pearah

Leon C. Darrah
Myer W. Dashe
Robert R. Impink
Archibald R. Judd
Mark D. Grim
Carl E. Sweitzer

BLAIR

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Elwood W. Stitzel, *President*
Augustus S. Kech
John O. Prosser
James S. Taylor
Ralston O. Gettemy
Charles Henry Bloom
Irvan A. Boucher

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Dominic S. Motsay, *Secretary*
Joseph B. Cady, *President*
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Morgan F. Taylor
Manley Rockman

BUCKS

William I. Westcott, *Secretary*
Arthur J. Ricker, *President*
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Elmer C. Laudenslager
Harvey D. Groff

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Edward C. Lutton, *President*
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Daniel Ritter
Arthur Miltenberger
Joseph P. Replogle

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Marvin R. Evans, *President*
B. Frank Rosenberry
William R. Bonner
Stanley F. Druckenmiller

CENTRE

Hiram T. Dale, *Secretary*
John H. Light, *President*
Joseph A. Parrish
William J. Schwartz
Eugene H. Mateer

CHESTER

Francis Jacobs, *Secretary*
Julius Margolis, *President*
Michael Margolies
Frank H. Ridgley
John A. Bellis

Horace F. Darlington
George W. Truitt
William A. Limberger

CLARION

James M. Hess, *Secretary*
Harrison M. Wellman, *President*
Theodore R. Koenig

CLEARFIELD

George C. Covalla, *Secretary*
Frances DeBone Taylor, *President*
Ward O. Wilson

CLINTON

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Forney D. Winner, *President*
Raymond A. Werts
Francis P. Dwyer
Gerard F. McDonough

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Robert Klein, *Secretary*
Joseph V. M. Ross, *President*
Charles S. Yost
Otis M. Eves
Daniel E. Witt

CRAWFORD

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Samuel E. Hoke, *President*
John H. Bailey
Luther J. King

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William B. Turner, *President*
Newton W. Hershner
E. Blaine Hays

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Hamblen C. Eaton, *Secretary*
W. Paul Dailey, *President*
George L. Lavery
Charles W. Smith
Dale C. Stahle
Carl E. Ervin
Luther A. Lenker
Henry F. Hottenstein
Constantine P. Faller
James S. Forrester
Kermit L. Leitner

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Ralph E. Bell
E. Wayne Egbert
Richard W. Garlich
E. Arthur Whitney
Harry K. Gabroy
John J. Hagarty
Joseph F. Dunn
Paul D. Shore
William H. Crawford

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Charles A. Hauber, *President*

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Ralph E. Schmidt
James D. Weaver
John F. Hartman
Herman W. Riester
Joseph M. Walsh

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Bruce Montgomery, *President*
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L. Dale Johnson
Harold L. Wilt

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Frank J. Corbett
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David L. Avner, *President*

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Herbert Curtis Long, Jr.

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S. Meigs Beyer
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Roy Deck
Edgar W. Meiser
Mahlon H. Yoder
Joseph Appleyard
Charles W. Bair
Samuel W. McNeal

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Mary Baker Davis
Charles H. Whalen
James L. Popp

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Harold A. Krohn
Herbert C. McClelland

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Robert L. Schaeffer
Gerald S. Backenstoe
Leo C. Eddinger
Morgan D. Person
John J. Wenner
Paul C. Shoemaker
Willard C. Masonheimer
Charles S. Hertz
Clyde H. Kelchner

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Louis W. Jones
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Rufus M. Bierly
Charles L. Shafer
Albert R. Feinberg
Nicholas R. Lakatos
Herman A. Fischer
Francis P. Judge
Russell A. Stevens
Frank M. Pugliese
Maurice J. Regan
J. Thomas Williams

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Louis E. Audet, *President*

Wilfred W. Wilcox
Hartford E. Grugan
Charles J. Rodgers
George N. Ballentine
Sidney E. Sinclair
Spencer W. Servoss

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Sophronous A. McCutcheon, *President*
Ralph E. Hockenberry
William J. Sigmund
S. Gordon Huff

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Dan Phythyon, *President*
Joseph J. Bellas
William J. Harrer, Jr.
Edgar L. Jamison

MIFFLIN

John R. W. Hunter, Jr., *Secretary*
Samuel L. Woodhouse, *President*
Joseph S. Brown
Bryce E. Nicodemus
James R. McNabb

MONROE

Harold B. Flagler, *Secretary*
Paul H. Shiffer, *President*
Charles S. Flagler
Charles H. Rushmore
David F. Kohn

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John D. Perkins, Jr., *President*
Edgar S. Buyers
William S. Colgan
Teofil Babacz
John M. Brecht
James J. McShea
Morris A. Bowie
M. Louise C. Gloeckner
Elmer R. Place
Katherine B. Vanderbilt
Elwood T. Quinn
Daniel W. Kirkpatrick
Walter J. Stein

MONTOUR

John A. Bealor, *Secretary*
James A. Collins, Jr., *President*
Henry F. Hunt
Roy E. Nicodemus

NORTHAMPTON

Thomas H. A. Stites, *Secretary*
James B. Butchart, *President*
Dudley P. Walker
Irene F. Laub
Russell S. Rinker
James Earl Brackbill
Robert H. Dreher
Ralph K. Shields

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Mark K. Gass, *Secretary*
John R. Vastine, *President*
T. Lamar Williams
Emily R. Shipman
Benjamin Schneider

PERRY

Frank A. Belmont, *Secretary*
Amos G. Kunkle, *President*
Robert N. Reiner
Leonard B. Ulsh

PHILADELPHIA

Malcolm W. Miller, *Secretary*
Henry B. Kobler, *President*

Delegates

(Elected to serve in 1949 and 1950)

John V. Blady	Hayward R. Hamrick
Frederick A. Bothe	Theodore Melnick
W. Edward Chamberlain	Eugene P. Pendergrass
Louis H. Clerf	Milton F. Percival
Walter S. Cornell	Frederick C. Smith
Theodore R. Fetter	J. Hart Toland
Leonard D. Frescoln	Joseph J. Toland, Jr.
Edmund L. Housel	Henry B. Kobler

(Elected to serve in 1950 and 1951)

William Bates	Guy M. Nelson
William P. Belk	D. Sergeant Pepper
Dorothy C. Blechschmidt	Isidor S. Ravdin
Francis F. Borzell	J. Parsons Schaeffer
John T. Farrell, Jr.	John J. Shober
Simon S. Leopold	Martin J. Sokoloff
Pascal F. Lucchesi	Adolph A. Walkling
Roy W. Mohler	William J. Zintl

Alternates

(Elected to serve in 1949 and 1950)

Earl A. Daugherty	Henry L. Gowens, Jr.
John W. Egoille	Robert L. Dickson
Edward W. Campbell	Jacob B. Bernstine
Rendall R. Strawbridge	William B. Swartley
Ralph W. Lorry	Ralph H. Spangler
Ernest E. Aegerter	Benjamin D. Parish
John C. Howell	Edward Weiss

(Elected to serve in 1950 and 1951)

Arthur H. Thomas	William G. Leaman, Jr.
William A. Decherney	Charles-Francis Long
John B. Montgomery	Philip Q. Roche
Nathan Blumberg	Donald Smelzer
David A. Cooper	Elsie Treichler-Reedy
Garfield G. Duncan	William A. Jeffers
DeHaven Hinkson	Rudolph Jaeger
Charles B. Hollis	

POTTER

George C. Mosch, *Secretary*
Clarence E. Baxter, *President*

SCHUYLKILL

Charles V. Hogan, *Secretary*
William T. Leach, *President*
Robert E. Hobbs
J. Stratton Carpenter
William H. Schlitzer
George A. Merkel
William V. Dzurek
Lewis H. Bacon

SOMERSET

Harold G. Haines, *Secretary*
George F. Speicher, *President*
Charles I. Shaffer
Charles B. Kornis
Jerry M. James

SUSQUEHANNA

Park M. Horton, *Secretary*
Waldron E. Greenwell, *President*
Edgar H. Lutz
John C. Cavender
Gordon E. Snyder

TIOGA

Eleanor Larson, *Secretary*
Sterling C. Basney, *President*
Thomas Dimitroff
Patrick M. Berzito
Robert S. Sanford

VENANGO

James E. Hadley, *Secretary*
Gale H. Walker, *President*
Frank E. Butters
Richard K. Frawley

WARREN

John C. Urbaitis, *Secretary*
John E. Thompson, *President*
Jacob F. Crane
Arthur J. O'Connor
John C. Thompson

WASHINGTON

Albert E. Thompson, *Secretary*
Raymen G. Emery, *President*
Guy H. McKinstry
Edwin L. McCarthy
Michael Krosnoff
Milton Manning
John C. Kelso
John S. Oehrle

WAYNE-PIKE

Harold W. Koch, *Secretary*
Richard A. Porter, *President*

WESTMORELAND

William E. Marsh, *Secretary*
Willis H. Schimpf, *President*
Derek H. Cross
Gervase F. Nealon
Anthony L. Cervino

Jo C. Griffith
 Lemuel D. Peebles
 John H. Kooser
 Leslie S. Pierce
 C. Leonard Hobough
 Paul A. Mankovich

WYOMING

Helen M. Beck, *Secretary*
 Arthur B. Davenport, *President*
 Charles J. H. Kraft

YORK

H. Malcolm Read, *Secretary*
 Norman H. Gemmill, *President*
 Josiah A. Hunt
 James E. Throne
 John H. Trimmer, Jr.
 Charles L. Fackler
 John J. Angelo
 Harry L. Fisher

County	Active Members		County	Active Members	
	1949	1950		1949	1950
Clinton	27	29	McKean ..	53	50
Columbia ..	45	44	Mercer	95	83
Crawford ..	53	58	Mifflin	37	39
Cumberland	47	47	Monroe ...	37	38
Dauphin ...	250	253	Montgomery	343	345
Delaware ..	294	297	Montour ..	39	38
Elk	25	25	Northampton	194	193
Erie	202	201	Northumb'l'd	75	76
Fayette ...	117	114	Perry	14	12
Franklin ...	77	78	Philadelphia	3182	3058
Greene	26	24	Potter	10	9
Huntingdon.	30	28	Schuylkill .	153	152
Indiana ...	43	40	Somerset ..	30	33
Jefferson ..	57	58	Susquehanna	17	14
Juniata	7	6	Tioga	27	26
Lackawanna	282	283	Venango ...	53	48
Lancaster ..	230	222	Warren ...	44	47
Lawrence ..	81	81	Washington	145	131
Lebanon ...	68	73	Wayne-Pike	22	23
Lehigh	223	223	Westmore'l'd	208	205
Luzerne ...	366	368	Wyoming .	12	13
Lycoming .	143	142	York	168	172

Total active membership—1949, 10,528; 1950, 10,259.

REPORTS OF OFFICERS

REPORT OF SECRETARY-TREASURER

To the President and House of Delegates:

Membership

The official membership of The Medical Society of the State of Pennsylvania on Aug. 7, 1950, included 10,282 physicians who paid dues for the current year; also 561 associate members who do not pay dues but receive the PENNSYLVANIA MEDICAL JOURNAL and other benefits of membership, excluding medical defense. In 1949, on the same date, 10,569 physicians had paid the year's dues.

One hundred and sixty-three members have been taken by death, 86 have been lost by resignation, and 145 by removal from Pennsylvania.

Twenty-four component societies show a gain in active membership during 1950; 31 show a loss, and 5 remain stationary.

The increase of 174 in the number of associate members this year over the number of one year ago may be explained by the 1950 increase in the amount of dues of many county medical societies, the inclusion of AMA dues, and the 1950 increase of \$8.00 in state society dues.

County society distribution of membership is as follows:

County	Active Members		County	Active Members	
	1949	1950		1949	1950
Adams	28	26	Bucks	89	89
Allegheny .	1642	1567	Butler	72	67
Armstrong .	41	42	Cambria ...	164	159
Beaver	136	129	Carbon	35	37
Bedford ...	15	11	Centre	34	35
Berks	259	247	Chester ...	114	117
Blair	124	117	Clarion ...	24	25
Bradford ..	51	48	Clearfield ..	49	44

Medical Defense

There have been no expenditures from the Medical Defense Fund during the past year.

One application for assistance from the fund has been approved:

No. 380. Application dated June 19, 1950. Plaintiff claims that negligence in operation for bilateral varicose veins of legs and thighs resulted in division of femoral artery during saphenous ligation and amputation of leg.

One case was closed during the year:

No. 372, in which plaintiff claimed neglect in treatment of child for bronchial asthma, resulting in child's death. Trial resulted, after 27 hours' deliberation by the jury, in split verdict of (a) "death action" in favor of plaintiff (\$65 awarded) and (b) "survival action" in favor of defendant.

Annual Audit

As has been the custom for 25 years, the usual annual audit* of the accounts of The Medical Society of the State of Pennsylvania was made in mid-August by Mr. Grant L. Bell, of Scranton. A copy of the auditor's report will be available for review to any interested member in the Society's offices in Harrisburg or Pittsburgh and in the offices of the Philadelphia County Medical Society.

In 1930 the Society's administrative expenditures required the writing of 297 checks; in 1950 the Society's ever-expanding activities in the service of its membership and the public required the writing of approximately 2000 checks. This mathematical expression of expansion serves also to reflect the need for more modern means of bookkeeping service.

* The financial section of the report of the secretary-treasurer will be published in the September issue of the JOURNAL. Preprints will be distributed prior to the meeting of the House of Delegates.

War and Defense Emergency

At this writing the prospects for increased county and state medical society responsibilities relative to war and civil defense emergencies are sufficient to suggest that the members of the House of Delegates come to the 1950 session with determination in their minds that the medical profession will, as always, play its full part in the rendering of professional service to the Nation's armed forces as well as the civilian population. Already there are evidences of the revival of Procurement and Assignment activities connected with the enrollment of doctors of medicine for military medical service.

Excerpts from the minutes of the July 27-28 meetings of the Board of Trustees and Councilors as they will appear in the September issue of the *PENNSYLVANIA MEDICAL JOURNAL* set forth the advance provisions made by the Board for the development of plans for the administration of Procurement and Assignment in Pennsylvania.

On Saturday, July 29, the president, the president-elect, secretary-treasurer, and the chairman of our State Society's Committee on Emergency Disaster Medical Service, with the latter committee's staff secretary, met in Washington, D. C., with similar representatives from six other eastern state medical societies, the District of Columbia Medical Society, and representatives of the National Security Resources Board and the Department of Defense.

These preliminary activities considered in connection with our nation's war position in the Far East may readily result, before the year 1951 is many months old, in not only a scarcity of medical service to the civilian population in Pennsylvania but in the reduction of from \$25,000 to \$40,000 in our state society's 1951 income because of remission of annual dues to a possible fifteen hundred or more of our present active members, which, if war history is to be repeated, will result in the wide dispersal for the third time in 35 years of many from our society's membership.

1950 Secretaries-Editors Conference

The thirty-ninth annual conference of county society secretaries and editors (no conference held in war years 1942-1945) in the Penn-Harris Hotel, Harrisburg, March 2 and 3, 1950, was marked by a 40 per cent greater attendance than any previous conference. Thirty-eight county societies were represented by the secretary or the editor, or both; 34 societies by the president or the president-elect; and 31 societies by the chairmen of such committees as Public Health Legislation, Medical Economics, and Public Relations.

The program features of the conference—if they should be expanded in future years as much as they were in 1950—may soon balloon this 43-year-old annual secretaries-editors conference into a two-day interim session, not only of the conference as known in earlier years but of the Board of Trustees and of certain active committees and commissions of the Society, plus the possibility of the Woman's Auxiliary to the State Medical Society holding its annual March conference of state and county society officers during the same period. The program this year was featured by two clever dramatizations of the separate appeals by the Society's Public Relations Committee and of the Medical Service Association of Pennsylvania.

The presence and participation of the Secretary and General Manager of the American Medical Association, Dr. George F. Lull, who attended all conference program sessions and was the featured speaker of the evening meeting, added greatly to the general interest. He also attended all sessions of our Board of Trustees.

The travel and living expenses of all who are invited to attend these instructive and stimulating conferences are paid by the State Society; therefore, the State Society officers may not be satisfied with less than 100 per cent representation at the conferences of all of our 60 component county medical societies.

Veterans Loan Fund MSSP

In our report to the 1949 House of Delegates it was stated that of the 57 non-interest-bearing loans made from the Veterans Loan Fund MSSP 13 had been repaid in full, with one 50 per cent repaid, and another with a fractional payment of \$25. Since our 1949 report, seven more loans have been repaid in full and two partially paid. Many of these repayments have been accompanied by expressions of appreciation, as *JOURNAL* readers may have noted in the Letters' Department.

On Jan. 23, 1950, we addressed a communication to the president, secretary, and treasurer of each component county medical society, informing them of the total amount pledged by members of their respective county societies; as well as the total amount paid on same, also giving information about loans against 90 per cent of the total paid in having been made to members of certain societies. The promise to return the balance available for each county society was followed by this statement: "The disposition of such balance should be preceded by consideration by your society of those who pledged and paid (see list enclosed). Some might also wish to consider the possibility of applying future payments on unpaid loans to projects of the county society such as building fund, library, etc."

To date we have had replies from but six county medical societies, and in two instances we have been requested to divide the cash balances allottable to their societies proportionately between those who paid on their respective pledges; the remaining three asked to have such balances returned to their society treasury. Considering this response too slight, no disposition of the balances has been made to date.

Deeming that further delay would bring no more replies to our widely spread communication of January 23, our Board of Trustees at its July meetings approved of prompt distribution of the entire balance in the Veterans Loan Fund MSSP, including the 10 per cent of the total originally received which, it will be remembered, had been maintained by the State Society as a reserve to the fund. During the month of August, therefore, the various proportionate sums were returned to the secretary or the treasurer of the various county societies with a copy of the Jan. 23, 1950 letter and a copy of the communication accompanying the check drawn against the now dissolved Veterans Loan Fund MSSP.

Locations to Practice

Our society's service to communities seeking physicians, and to physicians seeking locations in Pennsylvania, has dwindled proportionately to the extent that

inquiries have materially declined. Inquiries from communities now far outnumber inquiries from physicians seeking locations. To offset this disproportion, we have sent with our replies not only our list of Pennsylvania areas declaring their need for a physician to inquiring physicians but vice versa the names of inquiring physicians to community representatives.

Illustrative of the complexity of this problem, we mention the experience of one of our society's members practicing in a flourishing industrial town. In the past year, he has repeatedly declared the local need for another doctor who could be assured of hospital connections in two hospitals located within ten miles and of the probability of part-time industrial work on salary with a steel company. To this member we have sent from time to time the names of 15 doctors seeking locations, and no later than July 12 he again informed us that he had canvassed all whose names had been given him but without success.

Collecting 1950 AMA Dues

The experience that we are able to report on collection of 1950 AMA membership dues from the dues-paying members of our state medical society should prove heartening to those who may doubt the basic organizational unity expressed in the federation of the profession's county, state, and national medical associations. The fact has previously been emphasized that 94 per cent of our dues-paying members for 1950 also paid the AMA dues.

This office is most appreciative of the reaction of the membership and of the splendid service rendered by county medical society officers in the collection of not only their own county society dues but of state society and AMA dues which they remitted to this office. The 1950 House of Delegates of the American Medical Association accepted a recommendation of its Board of Trustees authorizing a refund of 1 per cent of the amount collected by each constituent state medical association. The amount to be received by our society, probably at the close of the year 1950, which will approximate \$2400, should be equitably divided with our component societies. For example, the State Society could retain 40 per cent and divide the balance on a per capita basis with county societies. The 25 cents returned by the AMA for each \$25 membership dues collected would, in the above proportion, result in returning 15 cents to the county society on each 1 per cent returned by the AMA to the State Society, the State Society retaining 10 cents.

It is a pleasure to be able to remind the members of the House of Delegates that AMA dues for 1951 remaining at \$25 will include the subscription to the *Journal AMA*, and that AMA fellowship dues will be \$2.00.

Conclusion

In closing his thirty-second consecutive annual report to the President and House of Delegates, your secretary-treasurer wishes to record again his sincere appreciation of the cooperative and responsive help received from national, state, and county medical society officers, committeemen, editors, and from the personnel of the Society's office staffs.

Respectfully submitted,

WALTER F. DONALDSON, *Secretary-Treasurer*

REPORT OF CHAIRMAN OF BOARD OF TRUSTEES AND COUNCILORS

To the President and House of Delegates:

At the meeting held on Sept. 28, 1949, Dr. Frank A. Lorenzo, retiring chairman and trustee and councilor from the Ninth Councilor District, presented the newly elected president-elect, Dr. Harold B. Gardner, and the first vice-president, Dr. Louis W. Jones.

Dr. Lorenzo then introduced two newly elected board members to serve for five years each—Dr. Gilson Colby Engel and Dr. Robert P. Banks, First and Sixth Councilor Districts, respectively.

At the organization meeting the Board of Trustees elected Dr. George S. Klump, trustee and councilor from the Seventh Councilor District, as chairman to succeed Dr. Lorenzo, and Dr. Thomas R. Gagon, Twelfth Councilor District, as vice-chairman.

At this meeting Board committee appointments for the ensuing year were announced as follows:

Finance—Drs. Whitehill, *chairman*, Walker, and Appel.

Publication—Drs. Gagon, *chairman*, Altemus, and Hogan.

Building Maintenance—Drs. Conahan, *chairman*, Engel, and Sweeney.

Library—Drs. Lorenzo, *chairman*, and Banks.

Benevolence—Drs. Samuel, *chairman*, Laurrie D. Sargent, Conahan, *treasurer*, and Donaldson, *secretary*.

Educational—Drs. Whitehill, *chairman*, Hess, Gloeckner, and Donaldson, *secretary*.

Dr. Donaldson was re-elected editor of the PENNSYLVANIA MEDICAL JOURNAL, Mr. Lester H. Perry was re-elected executive secretary, and Mr. A. H. Stewart, Jr., was re-elected convention manager and managing editor of the JOURNAL. Dr. Sweeney was renamed as the Board of Trustees' representative on the Advisory Council on Medical Service; and Evans, Bayard & Frick were re-elected legal counselors.

Dr. E. Roger Samuel, president, announced the appointment of Dr. Louise C. Gloeckner, second vice-president, as an ex-officio member of the Committee on Public Relations; Dr. Mark K. Gass, third vice-president, as an ex-officio member of the Committee on Public Health Legislation; Dr. L. Dale Johnson, fourth vice-president, as an ex-officio member of the Committee on Medical Economics; and Dr. Charles V. Hogan as vice-chairman of the Committee on Public Health Legislation.

Minutes of Board Meetings

Since the 1949 convention of The Medical Society of the State of Pennsylvania held in Pittsburgh, excerpts from the minutes of the meetings of the Board of Trustees and Councilors appear in the PENNSYLVANIA MEDICAL JOURNAL as follows: *September meeting*—March, 1950 issue, pages 277-279; *December meeting*—March, 1950, pages 279-282; *March meeting*—May, 1950, pages 530-537; and *May meeting*—July, 1950, pages 743-746. The minutes of the July meetings will appear in the Officers' Department of the September issue. All meetings were, as usual, well attended by the trustees and councilors, other officers, and the chairmen of the Committees on Medical Economics, Public Health Legisla-

tion, and Public Relations, as well as other state society commissions reporting progress or seeking advice and support from the Board of Trustees.

In addition to generous excerpts from the minutes of our meetings, which appear from time to time in the *PENNSYLVANIA MEDICAL JOURNAL*, mimeographed copies of the complete minutes of all meetings are available for reading by Society members in the Harrisburg and Pittsburgh offices of the Society, and in the office of the Philadelphia County Medical Society. Consequently, following precedent, routine activities of the Board will not be repeated in this report.

Building Expansion

Carrying on toward completion the plans adopted by the Board of Trustees at their March, 1949 meeting to provide adequate office space and facilities for the ever expanding functions and responsibilities of our state society, it is possible to report (July 5) that the alterations to the basement and the second and third floors of the former Laverty building (226 State Street) have been completed and practically all of the offices in our original building at 230 State Street are vacated in order that alterations including the installation of an elevator, air conditioning, and rearrangement in the front section of the latter building may result in completion of the well-laid architectural plans during the autumn of 1950. Readers of the *JOURNAL* who follow the minutes of the Board of Trustees will remember that approximately two-thirds of the estimated cost (\$90,000) was provided by the funds originally advanced by our society to the Medical Service Association of Pennsylvania and repaid in a lump sum (\$56,164.86) by the latter in June, 1948. The remaining amount has been borrowed from the Medical Defense Fund to be repaid as soon as possible with a low rate of interest in \$5,000 installments.

Educational Fund

A report of this Board committee will be found elsewhere in this issue of the *JOURNAL*. From this it will be noted that during this, its inaugural year, the committee's experience has been both satisfactory and revealing of great possibilities for invaluable assistance in carefully selected instances. It is also a pleasure to again call attention to the fact that former President Elmer Hess, of Erie, who fathered this idea in his presidential address (1947), has contributed \$1,000 to the fund.

Graduate Education Institute

This fine state medical society project, with the early May program presented at ten centers throughout the State, completed its first three-year planned course presented by scores of experienced medical school teachers and clinicians to hundreds of practitioners who avidly sought first-hand instruction. The latter's support of the project will be officially recognized at the time of the president's inauguration on Tuesday evening during the Society's 1950 convention in Philadelphia, at which time appropriate certificates will be presented relating to their faithful attendance and sustained interest in the instructive subjects planned for them by the Society's own Commission on Graduate Education with the invaluable cooperation of the deans of the medical schools in Pennsylvania.

Keystones of Public Health for Pennsylvania

So much has appeared on this subject in the last ten issues of the *PENNSYLVANIA MEDICAL JOURNAL*—excerpts from the minutes of the Board of Trustees, and a series of editorials based on the report—that at this time we will only call attention to the historic facts: (1) Our own 1947 House of Delegates suggested that such a survey be made and addressed its request to the Governor of the Commonwealth. (2) The Society received 536 complimentary copies of the completed 338-page report which the Society distributed to appropriate libraries, institutions, and persons in Pennsylvania. In order to meet the demand, our society later purchased 300 additional copies. (3) The editorials previously referred to were prepared by representatives of the commissions and committees of the State Society to whom various sections of the report were assigned for study and comment by the Board of Trustees upon recommendation by our own Commission on Preventive Medicine and Public Health. The 1950 House of Delegates may rest assured that during these studies of the Keystones survey report, which were cautiously conducted and conservatively reported, the Board policies on the two keystones approved by the 1949 House of Delegates having to do with sound personnel policy in the Health Department and the assumption of responsibility for proper administration of the Department's program at the local level were supported with proper reservations.

Duties of Board Members

Any member of the Society familiar with the duties assigned to a fellow member who has been elected to the dual position of trustee and councilor will realize that said duties are not limited to control of the financial affairs of this society. Other duties are "publication of the *JOURNAL*, general interim supervision over the conduct of all committees and commissions, and full control of all arrangements for the annual session." The Board in recent years has held meetings on three or four days during the annual session, and two consecutive days each in December, March, May, and July. In addition to these duties, each trustee as councilor "shall be judicial representative for his councilor district," considering with county representatives all questions involving the rights and standing of members, questions of an ethical nature, and shall visit each county society in his district at least once a year. Interested members may find comments on this press of official duties in the individual reports of the twelve trustees and councilors to the House of Delegates, and will note the proposed amendment to the By-laws eliminating the annual councilor district meetings.

Finances

Faithful readers of the *PENNSYLVANIA MEDICAL JOURNAL* who have followed the periodic reports by Secretary-Treasurer Donaldson set forth under the heading "1950 Honor Roll" must have been proud of the manner in which 96 per cent of our membership accepted the increase (\$8.00) in state society dues authorized by our 1949 House of Delegates, in September, and of the fact that 94 per cent also paid the AMA dues also approved by our 1949 House of Delegates. The

fine accomplishments of the past year and the challenging opportunities in the immediate future have been made possible by just two factors—dues and salaried and volunteer workers. One sometimes hears complaints that AMA and state and county society dues are too high. However, the total amount of dues that our members pay to all medical societies probably represents only a fraction of 1 per cent of their gross income.

The detailed financial statements from the office of the secretary-treasurer, which are distributed monthly to the Board of Trustees and are summarized at periodic meetings of the Board by its Finance Committee, serve to keep those who are held responsible for expenditures well informed and in a position to recognize extravagance in budgetary spending.

In Appreciation

The workers of the Society, the officers, its committee members and lay employees give unstintingly of their time and of themselves. One cannot single out individuals for special mention; the total picture is that of teamwork. The intense loyalty and interest displayed by these lay men and women in behalf of the Society cannot be bought. Part of their recompense must be in the feeling of a job well done. The unfailing cooperation, hard work, and esprit de corps of the staffs working with Secretary-Treasurer Donaldson and Executive Secretary Perry indicate the high caliber of leadership and administrative ability with which our society's offices are conducted.

Respectfully submitted,

GEORGE S. KLUMP, *Chairman*

REPORT OF THE EDITOR

To the Board of Trustees and Councilors:

A total of 63 editorials were published in twelve of the fifteen issues which will comprise Volume 53 of the PENNSYLVANIA MEDICAL JOURNAL. (Volume 54 will consist of the issues for the twelve calendar months of the year 1951.) Of the editorials, 26 were prepared by the editor and were unsigned; three were by members of the contributing editorial staff and were signed with their initials only, namely, Drs. Theodore P. Fetter (two) and James R. Watson (one); two by Managing Editor A. H. Stewart, Jr.; guest editorials, two each, by Drs. Douglas Macfarlan and Max H. Weinberg, and one each by Drs. George H. Ledger, Jonathan E. Rhoads, Edith E. Nicholls, C. L. Palmer, Robert P. Barden, Alfred Gordon, Barton R. Young, and John T. Ealy; Abraham Cohen and Thomas J. McBride; Alex. W. Ulin and Irving L. Lichenstein; Perk Lee Davis, Julian Love, and Robert Moxon; Harry M. Vars and James J. Jones; also one by Mr. A. S. Cobb, and two by William A. Challenger, Jr., Esq.

Six editorials of a series on the subject of nutrition were published, as prepared by Drs. Michael G. Wohl, Charles R. Shuman, John M. Higgins, James M. Strang, and Thomas E. Machella, members of the State Society's Commission on Nutrition.

At this point the editor would like to repeat that the editorial pages of the JOURNAL afford a fruitful avenue for the publication of comments by members of any of the Society's disease control commissions.

The assistance and effort put forth by Dr. Eugene P. Pendergrass and Chairman Wohl of our Commission on Nutrition in successfully obtaining guest editorials is herewith gratefully acknowledged.

In Volume 53 another series of nine editorials was published under the caption "Keystones of Public Health for Pennsylvania," with appropriate subheadings for the various subjects discussed. These were reviewed by the Society's Commission on Preventive Medicine and Public Health and were approved by the Board of Trustees and Councilors, as prepared by Drs. I. Hope Alexander (four), Ruth H. Weaver (two), Pascal F. Lucchesi, Vincent T. Curtin, John D. Yeagley, and Rufus S. Reeves (one each), representing various committees of our society.

Improvements in the front cover page of the PENNSYLVANIA MEDICAL JOURNAL, the use of a better grade of paper throughout, an expansion of line spacing conducive to easier reading, all of which were discussed in the editor's 1949 report and which added about \$4,000 to the annual cost of the JOURNAL, have been before the eyes of JOURNAL readers since the January, 1950 issue. While these improvements have received little favorable comment, there has fortunately been no unfavorable criticism.

We repeat our invitation of last year to JOURNAL readers to convey their criticisms of the JOURNAL contents by means of communications addressed to the editor, which may see the light of day in the JOURNAL's "Letters" department appearing in the forward advertising section of each issue. Criticisms of administrative functions of the Society may also be submitted for that department. All such must be signed, but the name of the writer will be withheld if requested.

The editor desires to express great appreciation for the valued assistance in his work of Miss Little of the Pittsburgh office staff, and of Mrs. Willners, editorial assistant, and managing editor A. H. Stewart, Jr.

It may be of interest in this report to announce again that the "History of Medicine in Pennsylvania—1848-1948" will be available to subscribers (\$4.50) before Jan. 1, 1951.

Respectfully submitted,

WALTER F. DONALDSON, *Editor*.

REPORTS OF INDIVIDUAL COUNCILORS

FIRST COUNCILOR DISTRICT

(Philadelphia County)

To the President and House of Delegates:

The annual First Councilor District meeting was held on March 29 at the Philadelphia County Medical Society Building in conjunction with that of the Woman's Auxiliary. About 110 persons attended the dinner meeting. Dr. E. Roger Samuel, president of the State Society, presented testimonial plaques to 18 physicians who had been in practice for 50 years. Professor Richard C. Reager, chairman of speech and debate, department of English, Rutgers University, spoke on "How to Tell Your Story."

The Benjamin Rush Awards for Philadelphia County

were conferred on Mr. Philip T. Sharples and the Philadelphia Society for Crippled Children and Adults, Inc.

The activities of the Speakers' Bureau continued to expand; 58 physicians gave 72 talks before lay groups on a variety of general health topics, particularly before school groups. In addition, many members of the society gave talks on compulsory health insurance or socialized medicine before numerous lay and professional groups, and large quantities of literature were distributed.

The attendance at the monthly scientific meetings improved, especially by reason of a change in program policy in which various aspects of a popular clinic subject are presented by a number of different local speakers followed by a question and answer period.

The board of directors, on the recommendation of the Tuberculosis Committee, requested the local city officials to make provision for necessary hospital beds and other facilities to meet the present urgent need for the care of active tuberculosis cases.

The Committee on Legislation is engaged in ascertaining how many physicians and members of their families are registered to vote. In addition, letters have been written to all candidates for public office, representing Philadelphia County, requesting their attitudes concerning vivisection, compulsory health insurance, improvements in certain aspects of the State Health Department, and strengthening of the Medical Practice Act.

A standing Committee on Stillbirths has been reactivated to study this problem and endeavor to reduce mortality in this field.

A special study Committee on Voluntary Health Insurance Plans has been organized for the purpose of assisting the society in evaluating the various available plans to meet the problem of the cost of medical care.

The Eye Section held another series of 12 postgraduate conferences with a registration of approximately 125. These conferences have been held annually since 1936.

The society is cooperating very closely with the local Red Cross Blood Center through a Medical Advisory Committee.

Discussions have been taking place between WCAU-TV and the society's Radio-Television Committee looking toward a regular television program emphasizing up-to-date medical diagnosis and treatment for education of the public.

The society's emergency medical call service began on Feb. 19, 1950, and is operating very satisfactorily and filling an important public need. During the first three months of its operation 459 calls were completed.

For the second consecutive year, provision was made for a student nurse scholarship. A similar scholarship was provided by the Woman's Auxiliary.

Representatives of the society, on invitation, appeared before the City Charter Commission to make recommendations concerning the health phases of the proposed new charter.

The Cancer Committee is engaged in a special activity to encourage physicians to conduct periodic health examinations in their offices with special reference to cancer detection.

The society was represented officially at the U. S. Pharmacopoeial Convention held in Washington, D. C., in May 1950.

The annual health poster contest had 33 participating schools which entered 255 posters. This represented an increase of 15 schools over last year and a 65 per cent increase in the number of posters entered. Three cash prizes were awarded in grades 4 to 6, grades 6 to 9, and grades 10 to 12, with three honorable mention awards in each group.

The society cooperated with the U. S. Public Health Service in furnishing physicians to examine boy scouts at their Jamboree in Valley Forge, Pa., which was held June 30 to July 8.

The twenty-seventh annual Strittmatter Award of the society was presented to Dr. Esmond R. Long, director of Henry Phipps Institute, April 12, for his many achievements in the field of tuberculosis.

The Disaster Preparedness Committee has been given increasing consideration to the medical problems of civilian defense, and expects very shortly to initiate a plan of organization in collaboration with the local Red Cross.

The fourteenth annual Postgraduate Institute of the society was held April 25-28 with a total registration of 3035 persons. In addition to the daytime lectures, the meeting was highlighted by two evening meetings—one a clinicopathologic conference and the other a discussion of the problem of alcoholism for the laity—and a dinner and floor show.

The Woman's Auxiliary continued to perform an effective service to organized medicine, especially with regard to health legislation and the society's public relations activities. The twentieth Health Institute of the auxiliary was held on April 11, and this annual affair again attracted an excellent audience.

Respectfully submitted,

GILSON COLBY ENGEL,
Trustee and Councilor.



SECOND COUNCILOR DISTRICT

(Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery Counties)

To the President and House of Delegates:

The membership of the Second Councilor District has increased in all its county societies.

Delaware County Medical Society celebrated its one hundredth anniversary with an excellent dinner party at the Real Estate Board Building in Upper Darby. State Society President E. Roger Samuel attended, as did Past Presidents Borzell and Estes. The principal address was delivered by President Judge Ervin of the Delaware County courts.

Your councilor would sound a word of caution about establishing grievance committees, fearing that we shall be busy listening to imaginary complaints of injuries to patients by our doctors. Recently a committee spent an afternoon listening to a tirade by an educated man who was censuring a doctor because he did not obtain for him a room in a hospital so he could be under said

doctor's care. He had never seen the doctor until the day of the hearing. His charges were inspired by a report in a lay magazine about the Colorado Medical Society's Grievance Board. In fact, he blamed the doctor for a three months' convalescence in another hospital. Instead of his family physician arranging for his hospitalization, he called this other doctor on the phone and asked that he get a room for him. His family doctor never called nor arranged for services from the hospital or the doctors. He was advised that he had no claim against the cardiologist and might consider looking to his family physician to accept any censure which might accrue.

Your councilor is concerned over the poor attendance at councilor district meetings. It is very distressing to the councilor who must arrange for a speaker; a discourtesy to the local officers and the officers of the district; and it bestows slight honor upon the recipients of the 50-year testimonials. Very few members appear; frankly, the results do not warrant the effort involved.

It is the councilor's opinion that we might have better attendance if we awarded the testimonials at a meeting of the local county medical society, holding the meeting in the town or city of the recipient, and with the meeting open to the public. Certainly the attendance could not be any worse than it is at the councilor district meetings.

Communities with small hospitals are alerted to the efforts of osteopaths to use existing hospital facilities. The usual beginning is made by having x-rays or laboratory work done. The Code of Ethics of the American Medical Association states:

"A consultation with a cultist is a futile gesture. It assumes the cultist to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice." (See page 56, January issue, PENNSYLVANIA MEDICAL JOURNAL.)

Hospital staff members should be constantly on guard to disapprove all proposals for the admission of cultists to hospital privileges. Those who either allege or follow in their practice a dogma which excludes demonstration and scientific experience should organize and maintain their own facilities for diagnosis and treatment.

While the councilor may have praise for activities of all county societies in his district, he feels constrained to give special recognition to the Lehigh County Medical Society for its great enterprise shown in the past year—(1) not only good scientific meetings, well attended, but (2) radio broadcasts, (3) newspaper advertising, (4) sixty-five members in its speakers' groups, and (5) a diphtheria immunization campaign. These activities have won national recognition, all because the entire membership put into them not only enthusiastic effort but their own money (\$20 assessment) in addition to annual dues. In a sentence, they spread the work and the word.

Respectfully submitted,

JOHN J. SWEENEY,
Trustee and Councilor.

THIRD COUNCILOR DISTRICT

(Carbon, Lackawanna, Monroe, Northampton,
and Wayne-Pike Counties)

To the President and House of Delegates:

The membership has increased in all county societies in the Third District during the past year, and all societies are holding meetings regularly as scheduled. More interest and better attendance have been noted this past year than at any time during the past six years.

Much more interest has been demonstrated in state society activities, and the response to the \$25 AMA membership dues, while not 100 per cent, has been much better than was anticipated at the beginning of the year.

The work of the woman's auxiliary in each of the component county societies has been excellent. Much credit is due to the untiring efforts of the State Auxiliary officers and of the councilor, Miss Mary Henry Stites.

On April 13 the annual meeting of the Third and Fourth Councilor Districts was held at the Hotel Bethlehem, in Bethlehem. The program, beginning at 10 a.m. and ending at 4 p.m., was provided by members of the staff of the Cleveland (Ohio) Clinic, the expense being absorbed by St. Luke's Hospital, Bethlehem. Approximately 920 invitations were sent to members in the two districts. The response was most discouraging. One hundred and seventy-nine doctors replied to the invitation. Of these, 113 indicated their intention not to attend. Sixty-six doctors attended the sessions and were well rewarded by an excellent program of instruction; 38 members of the Woman's Auxiliary were also present. From these facts, and our experience with former councilor district meetings, I am forced to believe that a continuance of councilor district meetings is not advisable.

Wayne-Pike County Medical Society is the smallest society in the district (26 members), but is very active. It cooperates willingly with all civic organizations and with the State Society in its endeavor to fight compulsory health insurance. The woman's auxiliary is active in all matters concerning the welfare of the medical profession and the general public.

Monroe County Medical Society, with a small membership (38 members), is active. A feature of its program, which I believe should be copied by other county societies, is its cooperation with the legal profession. Several times a year both professions meet, to the mutual benefit of all concerned. Four times a year they put on a radio program that is well received by the general public. The woman's auxiliary has been active, especially in the annual poster contest.

Carbon County Medical Society (37 members) is very active, particularly in the crusade against tuberculosis, cancer, and infantile paralysis. The woman's auxiliary continues its fine work. The attendance of members at district and state meetings is most commendable.

Lackawanna County Medical Society, the largest in the district (301 members), continues to do an excellent job. Space does not permit a detailed report of its accomplishments during the past year, but we name a few:

1. The emergency medical call service, established in 1947, covers the entire county, and covers it well.

2. There is excellent cooperation between state and local groups in matters concerning the welfare of patients and physicians. The Speakers' Bureau, headed by Dr. Frederic B. Davies, continues to be active. During the past year more than 20 organizations have been addressed by a qualified speaker.
3. The establishment of the Martin T. O'Malley award at a testimonial dinner to Dr. O'Malley on April 26 was an outstanding event—a fine tribute to a physician and gentleman after nearly 40 years of service.
4. The endorsement of a long-range program of the newly established Lackawanna County Chapter, American Heart Association, to eventually establish a convalescent home for rheumatic fever and heart disease patients is commendable.
5. The work of this society in the early diagnosis and treatment of cancer is extensive and plans for its future development have been mapped out. Some of them are: establishing housing for patients with cancer in its last stages; financing and sending a local physician and nurse to a medical center for the exclusive study of cancer; caring for the "intermediate class" of patients who are neither too rich nor too poor to receive terminal cancer treatment, and providing free transportation of cancer patients to the physician's office or hospital.

The new Committee on Alcoholic Problems and Rehabilitation, headed by Dr. George A. Clark, is doing a fine job. The results of their work will surely be recognized state-wide in a short time.

Lackawanna County Society lost a valuable member by death on April 5, when Dr. A. J. Winebrake died at his home in Dummore. For 50 years he was a conspicuous figure at county, state, and AMA meetings.

Northampton County Medical Society (204 members) has conducted well-attended meetings and much interest has been displayed by the younger members.

On November 30 this society celebrated the completion of one hundred years of existence. The celebration took the form of a cocktail party and dinner at the Hotel Bethlehem. State Society President Samuel and four past presidents attended.

The woman's auxiliary did an excellent job during the year under the leadership of Mrs. Brenholtz.

Respectfully submitted,

FRANCIS J. CONAHAN,

Trustee and Councilor.



FOURTH COUNCILOR DISTRICT

(Columbia, Montour, Northumberland, Schuylkill, and Snyder Counties)

To the President and House of Delegates:

We of the Fourth Councilor District have been very proud because of the selection of E. Roger Samuel from our district as president of The Medical Society of the State of Pennsylvania, and we know that he is covering the State from border to border, county by county, preaching the gospel of good will and serving as our best public relations representative of the State Society. He was honored in his own community at a dinner,

when he was presented with a plaque from the members of the medical profession of the Fourth Councilor District. I had the privilege of representing the State Society as the speaker on this occasion. Dr. Samuel is one of the very few general practitioners who in many years have graced this high office.

There has been a notable increase in interest in the scientific meetings of the component societies comprising the Fourth Councilor District. It is believed that this has been fostered by the county society presidents who have been stimulated by nearby graduate institutes which are arranged by our state society.

We combined our councilor district meeting with that of the Third Councilor District, at Bethlehem, where we had the opportunity of spending the day with our fellow-councilor, Francis J. Conahan. The story of this meeting is being reported by Dr. Conahan. The attendance at this session was not as good as we had desired and we remain of the opinion that these councilor district meetings as now constituted do not receive adequate support from the profession. This also applies to the meeting of the Woman's Auxiliary, which was poorly attended.

The following are reports by district censors representing the societies of our district:

Columbia County: An emergency medical call service has been instituted in the county. The Berwick and the Bloomsburg Hospitals cooperate in this service. Attendance at the society meetings as usual is good and the members have cooperated freely with the state society Committee on Public Relations.

Montour County: This society in conjunction with the Geisinger Hospital has again conducted the twice-a-year famous Geisinger Clinics, and your councilor along with Dr. Samuel had the privilege of addressing this group during the luncheon hour the day of the clinic on May 19. A combined meeting of this society with its woman's auxiliary and numerous guests was addressed on June 20 by William S. Livingood, secretary of the Pennsylvania Department of Internal Affairs. His subject was "Socialized Medicine."

Northumberland County: Northumberland, the home county medical society of Dr. E. Roger Samuel, current president of our state society, has been greatly honored by this distinguished recognition of one of its leading general practitioners. Dr. Mark K. Gass, of this society, is also serving as third vice-president of the State Medical Society.

Schuylkill County: Again I am happy to report on the condition of my own society, which has shown an increased attendance at meetings over that reported last year. The scientific sessions have been of the best and many top men of our profession have appeared before the society as speakers. Many of the members have been active in radio and in appearances before clubs and organizations. The woman's auxiliary has shown a satisfactory growth during the year and has been active in augmenting the work of the Schuylkill County Medical Society.

I want to thank the officers of the component societies in my district and all the committee members and chairmen of the society and the woman's auxiliary for their increased efforts in behalf of organized medicine. I par-

ticularly want to thank the members and friends who have cooperated with the important Public Health Legislation Committee of our state society. I also want to extend our thanks, once again, to Walter F. Donaldson, our secretary, and to our efficient staff at 230 State Street in Harrisburg, who have made it possible for your councilor to carry on this important work.

Respectfully submitted,

CHARLES V. HOGAN,
Trustee and Councilor.

FIFTH COUNCILOR DISTRICT

(Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York Counties)

To the President and House of Delegates:

During the year 1949-1950 your councilor covered, by personal visits, five of the counties in this district. He regrets very much that he was unable to make a swing of the western counties which are the smaller in his district and, therefore, more in need of his attention in order to convey their ideas to the State Society.

The councilor district meeting was held on May 18, under the auspices of the York County Medical Society, at the Caledonia Inn. At first your councilor was fearful that the location of the meeting would affect the attendance adversely. This proved not to be the case, as there were approximately 50 physicians present. What is more to the point, the location permitted the members of the western counties to attend in greater force than ever before. This is evident from the fact that the attendance at the meeting was the same as in previous years in spite of the fact that the largest county, Dauphin failed to have any member present.

The Woman's Auxiliary held its meeting at the same time and swelled the attendance to between seventy-five and eighty.

As a result of the above visitations and the councilor district meeting, your councilor was able to ascertain the thoughts of the membership on various subjects.

Public Health Legislation

The impression was gathered that the physicians are alert to the value of being interested in the subject of public health legislation. They were unaware of their negligence in registering and voting, but have taken steps to correct this. They recognize the importance of sending letters to legislators, both national and State. They object to the suddenness of requests from state or county committees, and the more so, when such requests are not specific enough to either acquaint them with or recall to their memory the nature of bills they are to oppose or endorse. There is a general weakness throughout the district in the chairmanship and/or working membership of the county Committees on Public Health Legislation. They believe that this is due to the change in membership of these committees, annually, with the election of new county presidents.

Education Campaign and Public Relations

There seems to be some general dissatisfaction with the Education Campaign work in the individual county societies. County committees and subcommittees are

more or less organized throughout. They are apparently failing to get endorsements, although some counties report a satisfactory number of speaking engagements. The dissatisfaction seems to stem from the fact that there is not much noticeable local use of the national funds. Also, the physicians are not entirely sold on the effectiveness of the pamphlet idea. They are satisfied with the personal contacts they can make with their patients.

In regard to the general public relations program of the county society, this depends upon the size of the society. A few of the counties have joined with other health organizations in putting on very successful public health displays.

AMA Dues

The membership of this councilor district seem very well satisfied with the AMA dues. However, they do not see the necessity for dual membership in the AMA and desire that the fellowship be abolished.

Grievance Committees

As a general rule throughout the district the membership is opposed to state-wide, district-wide, or highly publicized county grievance committees. They fear that such committees would be an open invitation to the public to register complaints against the doctor for not only real but thousands of fancied wrongs. They believe this avalanche of complaints would be embarrassing to the physician, restrict his freedom of action, and by its magnitude be poor public relations for the profession as a whole. A minority of the membership in this district believe otherwise, and are at present organizing such grievance committees in counties in which they hold the majority. These members argue that such committees are a right of the public and, by recognizing this right, the county society will in the long run deter many complaints and will have organized a potent public relations weapon.

Respectfully submitted,

JAMES Z. APPEL,
Trustee and Councilor.

SIXTH COUNCILOR DISTRICT

(Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin Counties)

To the President and House of Delegates:

The year 1949-1950 is the first year that I have served in the capacity of councilor, and not nearly as much has been accomplished as I desired. I have attended all the meetings of the Board of Trustees. I have visited all the societies except Clearfield and Blair, and before frost comes I plan to visit them. I have been very courteously received by all the societies visited.

Mifflin County has set up an emergency medical call system, using the local hospital as a call center, and I am informed that it is working well and the people seem satisfied that they can get a doctor 24 hours a day, seven days a week.

One of the activities of the Centre County Society was a joint meeting with pharmacists and dentists, and Dr. James W. Hershberger has informed me that the

Blair County Society had sponsored a picnic at which they were also joined by the pharmacists. More physicians are showing an interest in politics and are quietly working to preserve "the American way of life."

On May 18 our annual councilor district meeting was held at the Centre Hills Country Club, State College. A series of events had been planned for this occasion, but a pouring rain intervened. The auxiliary met at Nittany Lion Inn, and Mrs. Gettemy, of Altoona, conducted her last meeting as Councilor. It has been a pleasure to have been associated in this work with Mrs. Gettemy, the very efficient and able councilor of the auxiliary. She now bows out after very satisfactory service to her group. We had as our honor guest Dr. Francis A. Stiles, of Richfield, who was presented the 50-year testimonial plaque for good and faithful service. Drs. Gregg and McAleese, of Pittsburgh, gave a splendid discussion of "Heart Conditions in Children" and of surgery to correct them. They made a fine team and were well received.

The dinner in the evening, at which more than 100 persons partook of T-bone steaks, was a huge success, made possible by the work of Dr. Hiram T. Dale and his able committee. Dr. Harold B. Gardner, of Pittsburgh, president-elect of The Medical Society of the State of Pennsylvania, gave a short talk and presented the 50-year testimonial plaques. Dr. Joseph D. Findley, of Altoona, having passed away, his 50-year testimonial plaque was given to the district censor, Dr. Hershberger, to present to the family of the deceased. Mr. Lester H. Perry, of the Harrisburg office, addressed the meeting, as did also Mr. Keith Hutchison, western field representative of our State Society's Committee on Public Relations. The reports of the various societies composing the district were read by their respective district censors. The rain had ceased and all left for home feeling that they had attended a very worth-while meeting.

Respectfully submitted,

ROBERT P. BANKS,

Trustee and Councilor.



SEVENTH COUNCILOR DISTRICT

(Clinton, Elk-Cameron, Lycoming, Potter,
and Tioga Counties)

To the President and House of Delegates:

The activities of the component county societies of the Seventh Councilor District in 1949-1950 demonstrates that one of their main objectives has been education of the members and of the public. This is both proper and desirable. Indeed, if one reviews the constitutions of the American Medical Association, The Medical Society of the State of Pennsylvania, and professional societies such as the Pennsylvania Academy of General Practice, it becomes apparent that education is the true and tangible goal of organized medicine.

Councilor District Meeting

The Williamsport Center of the Graduate Education Institute had registrants from all counties of the district as well as several contiguous counties. A brief luncheon program was arranged on May 3 for the councilor dis-

trict meeting to coincide with the last session of the Institute. The attendance was gratifying—between 25 and 30 per cent of the membership. President-elect Harold B. Gardner presented a sincere exposition of "Our Role in Public Welfare." It was a fine talk directed at you, the member. Do read it in the July PENNSYLVANIA MEDICAL JOURNAL. Others on the program were Dr. Charles Wm. Smith, chairman of the Commission on Graduate Education, and Mr. Leo E. Brown, executive assistant to the Committee on Public Relations.

SUMMARY OF CENSORS' REPORTS

County	Membership		Emergency Medical Call Service	Interest in Elections
	1949	1950		
Clinton	28	31	Wednesday and Sunday	Increased
Elk-Cameron	25	26	"Talking stage"	Increased
Lycoming	150	156	Yes	Increased
Potter	10	Written report not received.		
Tioga	25	27	"None needed"	Increased

The assistance of the Committee on Public Relations in furtherance of the National Education Campaign is appreciated throughout the district. Mr. Keith Hutchison has appeared before the Elk-Cameron Society and Mr. Leo E. Brown has encouraged the effort at meetings in Clinton, Lycoming, and Tioga Counties.

Lycoming County reports the need for a general practitioner in Ralston, and for a physician qualified in neurology and/or psychiatry in Williamsport.

Woman's Auxiliary

Mrs. Howard H. Hamman, president-elect of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, was the honor guest at a delightful luncheon arranged by Mrs. Harry W. Buzzerd, councilor of the Seventh District. Dr. Gardner and Mr. Brown spoke briefly.

It has been our privilege in recent years to watch the development of the Auxiliary under the enthusiastic tutelage of Mrs. Paul C. Craig, Mrs. Drury Hinton, and now Mrs. Hamman. Whatever else may be said of these ladies in laudation, it should be recorded that each has done and is doing outstanding work for all citizens, and it too is almost entirely educational. We, the profession, are indeed fortunate in having such able women willing to serve the Auxiliary as head "man." Their programs have been made increasingly effective by the assistance of Miss Suzanne Treadwell and the unselfish work of the auxiliary councilors and members. Thanks, ladies!

Health Council

Last year the Lycoming County Medical Society reported tentative arrangements for a course on public presentation. The course was completed early in 1950. As a graduation exercise a dozen or more doctors each invited a guest to a businessman's-type meal. The guests were men who hold key offices in local labor unions. Among others present were doctors of dental surgery, insurance men, and teachers. A formal presentation of our Education Campaign viewpoint was made by the chairman of the Speakers' Bureau and this was followed by a real hair-down round table.

According to qualified observers, the most effective approach was the sincere offer of the local medical society to assist in the formation of a health council with proper representation of consumer interests. Such a council must first act as a study group, and it is hoped that a county-wide plan for distribution of medical care to all segments of the population will evolve.

In a rural area, such as this is, an effective health council might well extend its studies to include contiguous counties and municipalities that may comprise the area served by a local public health unit.

Councilor Duties

This is a quotation from a recent letter from Secretary-Treasurer Walter F. Donaldson: ". . . a board (Board of Trustees) whose members perhaps have too many responsibilities assigned to them. As a result, some of their local responsibilities as councilor are neglected which in my opinion may eventually be absorbed by . . . men like Lester Perry, Leo Brown, Keith Hutchison. . . ." Dr. Donaldson expresses very well what some of us who serve you in various capacities would like to say.

The first person has never before been used in my reports, but I must now appeal to the members of the district in this way. Your understanding is sought, for certainly I have not been able to visit each society nor to sit down with you as individuals for long overdue discussions. Attendance to the duties of delegate to the American Medical Association at its clinical and annual sessions together with interim committee assignments incident thereto and the work as a member of the Commission on Preventive Medicine and Public Health have made free time or vacations away from medical meetings but pleasant memories. One does these things because of some sort of an ego drive, I suppose. These are jobs to be done and I have no regrets whatever for making the effort. But Dr. Donaldson is so right! The solution, it appears to me, is to spread the work. That means that every member must pull his full weight in medical organization and that at least 20 per cent of us must be willing to offer a week or two from our practices, spread throughout each year, to attain this end.

Respectfully submitted,

GEORGE S. KLUMP,

Trustee and Councilor.



EIGHTH COUNCILOR DISTRICT

(Crawford, Erie, Mercer, McKean, and
Warren Counties)

To the President and House of Delegates:

The Eighth Councilor District had three fine meetings during the past year.

In the winter, Erie County Society had a centennial dinner with at least 300 lay guests representing all walks of life and all types of business from the laboring man and union officials to large industrial concerns and their officials. Wives of the society members and guests were also present. The speaker was an American Airline official and former newspaper man. The talk was on current affairs of the nation. This timely subject was well received by the audience.

As a public relations gesture this meeting was out-

standing. With such a cross-section of the people the county society was able to present the physician's side of the work of the medical profession in keeping the health of the nation at a high standard to many more than would be possible by any other means.

The second outstanding meeting was held by McKean County Medical Society at Bradford in March, to which the editors of Bradford County were invited. Dr. C. L. Palmer was the speaker and the discussion included the views of the editors. Many pertinent and valuable points from the lay side were stressed by the editors. We as physicians are not able to see ourselves as others see us and need to have the mirror held in front of us at times. We do not need to worry much about the unusual discoveries in science, but we do have to worry about the little things in our everyday contacts with our patients. It is these little things that build good or poor public relations.

The councilor district meeting was held on June 21 at the Stem Memorial Hospital in Union City. This hospital was built by the community without federal or state aid, costing \$3,000 a bed. It contains 34 beds, 16 bassinets, and 3 incubators. The building is one story with basement. The patients' rooms are all on the south side with large windows. The work rooms are on the north side. The basement has a large assembly hall and small dining rooms besides the utility and storage rooms. In every way it is a modern complete institution and well serves the needs of the community.

The meeting was attended by 110 persons. An excellent buffet luncheon was served, after which five 50-year testimonials were presented by Dr. Luther J. King, of Meadville, and a citation was presented by Dr. C. L. Palmer to the Honorable LeRoy E. Chapman, M.D., of Warren, for his outstanding work in the State Senate. The speaker was Dr. Philip Thorek, of Chicago, who spoke on "Abdominal Pain." Dr. Thorek is an entertaining speaker, combining humor with fact in such a way that his points are well remembered.

The censors' reports showed a small drop in regular memberships. While there was a good increase in new members, many of the older members have taken associate memberships.

All counties in the Eighth District have established an emergency medical call service.

Respectfully submitted,

HERMAN H. WALKER,

Trustee and Councilor.



NINTH COUNCILOR DISTRICT

(Armstrong, Butler, Clarion, Indiana, Jefferson,
and Venango Counties)

To the President and House of Delegates:

The Ninth Councilor District enrolls a total of 279 active members, 10 associate members, and one affiliate member, with 25 active members in the smallest society (Clarion) and 67 in the largest (Butler). During the year 21 new members were gained in the district; seven members died and five moved out of the State.

The annual councilor district meeting was held on June 15 at the Punxsutawney Country Club. In the opinion of the councilor this was a most outstanding meeting and all in attendance (109) expressed their ap-

proval of the scientific program given by three members of the Lahey Clinic in Boston, namely, Drs. S. Allen Wilkinson, Frank P. Foster, and Samuel F. Marshall, whose subjects were "Diagnosis and Treatment of Biliary Disease," "Diagnosis and Treatment of Menstrual Irregularities," and "Carcinoma of the Gastrointestinal Tract," respectively.

I do not agree that councilor district meetings should be discontinued, but feel that if interesting enough programs were prepared, more members would attend. One member of the Ninth Councilor District, Dr. Harry R. Wilson, of Butler County, received a testimonial plaque for the completion this year of 50 years of medical practice.

No emergency medical call service has been established in the Ninth Councilor District, but efforts are being made through the doctors and hospitals to supply such service.

District censuses from the various county societies in the Ninth District reported concerning their activities. Armstrong County Society has 42 members in good standing compared with 41 in 1949. No district in the county was reported in need of a general practitioner. It is believed that there is an increased interest in the primaries and general elections which is favorably influenced by the woman's auxiliary in the county.

Butler County Society has 67 members in good standing compared with 72 in 1949. Several rural districts were reported in need of a general practitioner. This society has supported the National Education Campaign in favor of voluntary forms of insured medical service and hospital care and has accepted freely of the assistance proffered through Mr. Keith Hutchison, representative of the Public Relations Committee in the western part of the State.

As was the case in 1949, Clarion County Society was again not represented at the councilor district meeting. This society enrolls 25 members in good standing in comparison with 24 in 1949. Five scientific and business meetings are held during the year.

Indiana County Society reports 40 members in good standing in comparison with 43 in 1949. One rural district is reported in need of a general practitioner. The members of the society and its woman's auxiliary checked on the registration of physicians and their families in the county and reported almost 100 per cent registered to vote in primary and general elections. Ten meetings were held during the year.

Jefferson County Society reports 57 members in good standing. Nine business and scientific meetings were held, two of which were combined with Clearfield County Society. One district in the county was reported to be in need of a general practitioner. The society is cooperating with the Public Relations Committee of the State Society, and radio programs are broadcast. Increased personal interest in primary and general elections is apparent.

Venango County Society reports 48 members in good standing in comparison with 53 in 1949. No district in the county was reported in need of a general practitioner.

Respectfully submitted,

FRANK A. LORENZO,
Trustee and Councilor.

TENTH COUNCILOR DISTRICT

To the President and House of Delegates:

In the past year the activities of the county medical societies composing the Tenth Councilor District have laid emphasis on two important functions of a good county medical society, namely, graduate instruction for its membership and training in the art of extending the socio-political influences of our profession. The Tenth District, which is heavily dotted with approved hospitals, affords fine facilities for the delivery of good medical service, and it is believed that the people of the counties in this district are the beneficiaries of unexcelled medical service and hospital care. The results of the good influence in keeping the medical profession of a district apprised of medical progress which flows from a medical school located in the district, and the intangible reactions arising from the practitioners' frequent contacts in hospital wards and laboratories and in staff conferences, must necessarily be reflected in morbidity and mortality records, and it is believed that such records throughout the Tenth Councilor District will bear favorable comparison.

The county societies of this district are expending considerable effort, and, in the instance of the Allegheny County Medical Society at least, considerable money on programs for the benefit of the public that are inherent in their respective emergency medical call service facilities.

Each society during the past year has endeavored to bring to interested civic, social, and other community groups the far-reaching and influential national education program of the American Medical Association.

It is comforting to the councilor to note from the honor roll appearing in the JUNE PENNSYLVANIA MEDICAL JOURNAL that 95 per cent of the members of Beaver County Medical Society paid their state society dues, and of this percentage all but three members paid 1950 American Medical Association dues also.

In Lawrence County Society, where 100 per cent of the membership paid state society dues, only one member did not pay AMA dues.

In Westmoreland County Society 96 per cent of the membership paid state society dues and 8 members did not pay AMA dues.

In Allegheny County Society, with 1566 members paying 1950 state society dues, or 98 per cent of its membership, 230 did not pay AMA dues. This considerable defection occurring in this splendid county medical society may be traced to the fact that at the October business meeting of the society, at which the annual dues for the following year are fixed, the board of directors recommended that 1950 AMA dues of \$12 be included with county and state society dues, but omitted the proviso "subject to action by the AMA House of Delegates at their December interim meeting," which fixed dues at \$25. Many members of the county society paid their dues in December and have since failed to pay the additional \$13.

The woman's auxiliaries throughout the Tenth Councilor District have rendered a service during the past year which reflects adequate response to every request for activity received from their respective county medical societies or the officers and representatives of the State Society. However, much remains to be done in

the way of obtaining formal signed resolutions in protest against compulsory health insurance. This activity has been referred to as the "grass roots" voice of Pennsylvania, and it is estimated that it will not have been adequately expressed until the present total of approximately 700 resolutions from Pennsylvania has been doubled, and a field of real and potent influence on national legislation thereby thoroughly explored.

The attention of the House of Delegates is especially directed toward stimulation of interest on the part of all county medical society members with their woman's auxiliary members in this fertile local source of influence. There are from a score to a hundred organizations in every county in Pennsylvania capable and willing, if solicited, to originate appropriate resolutions against socialized medicine.

The 1950 Tenth Councilor District meeting, held June 8 in Hotel Schenley, Pittsburgh, was disappointing from the standpoint of attendance but rewarding in its social features. This has been a repeated experience in recent years and reflects the keener interest of the older members of our profession in meeting with their colleagues as well as the indifference of the younger members who remain away from such meetings in large numbers. Apparently the latter wish the program emphasis to be on the science of medicine, and perhaps they have not yet realized the importance of social contacts and acquaintanceships with the older practitioners who are schooled in the art of medicine.

I hope, therefore, that when the House of Delegates acts upon the proposed amendment to the By-laws, deleting the required holding of annual councilor district meetings, it may remain possible for the trustee and councilor who deems it advisable to arrange such a meeting in his district.

Respectfully submitted,

JAMES L. WHITEHILL,
Trustee and Councilor.

ELEVENTH COUNCILOR DISTRICT

(Bedford, Cambria, Fayette, Greene, Somerset,
and Washington Counties)

To the President and House of Delegates:

All the counties in the Eleventh District have an organized society, with officers, and hold regular meetings. Some of the societies do not hold meetings every month. Usually a scientific paper is presented and discussed at the meetings, often by a guest speaker from outside the society.

The meetings at which I have been present seemed to be fairly well attended, although there is still room for improvement along these lines. Some of the societies have a dinner for the guest speaker, which I think is an excellent idea as it helps to stimulate good fellowship within the society.

The American Medical Association's Education Campaign has been received fairly well by the county societies in most instances, although there has been some criticism, no doubt justly so; but on the whole I believe the societies have tried to accept the program wholeheartedly. They have had conferences with Mr. Hutchison and have made an attempt to carry out his

suggestions in organizing the education program. Mr. Hutchison has been very helpful and deserves much credit for the work he has done in the western part of the State.

The annual councilor district meeting was held this year at the Hotel George Washington in Washington, with the Washington County Medical Society as host. An excellent program had been arranged for both the councilor meeting and the Woman's Auxiliary.

The scientific meeting began at 10 a.m., and continued until 4 p.m. The 50-year testimonial plaques were presented at the luncheon meeting by Dr. Louis W. Jones, first vice-president of The Medical Society of the State of Pennsylvania, his presentation being broadcast by the local radio station. The attendance was about average for the councilor district meeting.

A means to promote closer association and, I believe, help build better public relations between the county societies and the State Society would be to have a three-man advisory committee from each county society in the district. Meetings could be held with the councilor to discuss any problems of concern to the county and state societies. These meetings, of course, would not replace the councilor's annual visit to each of the county societies where he can hold a conference with the officers of the county society.

Through conferences with the three-man committee, problems of the county medical society could be brought to the state level and a much better understanding of the problem could be had at both levels. This committee could be appointed by the president of each county medical society.

Respectfully submitted,

LEARD R. ALTEMUS,
Trustee and Councilor.

TWELFTH COUNCILOR DISTRICT

(Bradford, Luzerne, Sullivan, Susquehanna,
and Wyoming Counties)

To the President and House of Delegates:

The county societies of the district maintain the same high level of interest in organizational affairs and scientific progress as in the past. It would be heartening, in fact it is essential, that more of the younger members become more active in the affairs of their society, and it is suggested that the presidents give recognition to this group by committee appointments, invitations to present scientific papers, or in any and various other ways make them feel that they are in fact, rather than fancy, a very real and important part of the organization. Upon these shoulders falls the mantle of guidance of organized medicine of the future; into these hands will be placed the torch of truth and honor. We who now hold positions of trust and responsibility must see to it that this mantle and torch are taken up by members who thoroughly understand all the high ideals that organized medicine always has, and always will, stand for without compromise or equivocation.

The woman's auxiliaries have been of inestimable help in the National Education Campaign. Their members have served in a great many capacities at various public meetings, whether under our own or other auspices,

with the type of unselfish devotion—sacrificing valuable time and performing downright hard (and sometimes not very agreeable) assignments—that is found only in the doctor's wife. We are deeply grateful to all of them for their record of accomplishment, not only in the immediate past but throughout the many years in which they have been of such valuable assistance. We know that this interest and helpfulness will continue in the crucial campaign that lies just ahead of us.

We earnestly urge close attention, thoughtful study, and consideration of the Keystones of Public Health for Pennsylvania, more popularly known as the Kandle Report, which undoubtedly will be presented by the Commission on Preventive Medicine and Public Health for action.

A study committee on this report, consisting of outstanding and impartial lay individuals and physicians, was formed by the Wyoming Valley Community Council to analyze that part of the report as it pertains to Luzerne County, that county having been surveyed as a rather typical geographic unit of the Commonwealth. Your councilor has the privilege of being a member of this group under the chairmanship of Dr. Lewis T. Buckman, past president of our state medical society. Subcommittees were appointed for study of each section of the Keystones report and they have in turn reported to the steering committee. The work is not quite completed, but has progressed sufficiently to conclude that the Kandle Report, insofar as it concerns Luzerne County, is far from accurate, and its conclusions and recommendations were arrived at from a very superficial and hasty investigation. We emphasize that this opinion is ours, *not* that of the Community Council, but we are equally emphatic in saying that the opinion can be substantiated by the reports made by the study subcommittees that were appointed. For these reasons we hope that a free and full discussion of the Keystones of Public Health for Pennsylvania will be held by the House of Delegates before definite action is made a matter of record.

The annual councilor district meeting was held at the Irem Temple Country Club, at Dallas, on June 21. It was an unusual honor and a memorable pleasure to present to six members of the district the 50-year testimonial plaques of The Medical Society of the State of Pennsylvania. Only one of the honored gentlemen was unable to be present due to physical disability. An intensely interesting and instructive address was given by Dr. John B. Trunnell, of The Sloan Kettering Institute, New York City, on "The Use of Atomic Energy in Medical Practice." Dr. Trunnell graciously interrupted his journey to California to fly to Wilkes-Barre in time for the meeting, taking another plane in the late afternoon for the West. We wish we could report an attendance worthy of the event and the address, but regretfully, and with no little embarrassment, we say that it was no better than in past years. The physician population of the Twelfth District is approximately 450, and of the 88 persons attending the meeting, 18 were guests. Only 43 physicians were present, the remainder of the group being members of the Woman's Auxiliary. This obviously is slightly less than 10 per cent of the physician population. The House of Delegates must give consideration to the futility of continuing councilor

district meetings. Year after year we have asked that these meetings be eliminated, and we feel confident that a majority of the councilors are now of the same opinion. We noted that a majority of the physicians present were from the ranks of the Old Guard, "that dies but never retreats," and whose places in the ranks are not being filled.

As we see it, the one great endeavor, the one immediate and urgent need of organized medicine in the months that are just ahead, is to *get out the vote in November*. Our education campaign must be carried on with increased fervor and lucidity, but our endeavors will bear no fruit unless we make every effort to have every citizen exercise his precious right of franchise, and have him register his vote for either a nation of freedom or one controlled by a government of centralization of power and quasi dictatorship.

Respectfully submitted,

THOMAS R. GAGION,
Trustee and Councilor.



REPORTS OF STANDING COMMITTEES

COMMITTEE ON MEDICAL ECONOMICS

To the President and House of Delegates:

There have been no formal meetings of the committee to date. Your chairman has attended all meetings of the Board of Trustees and Councilors and a meeting of the special committee to study President Engel's recommendations to the 1949 House of Delegates.

Copies of a paper entitled "The Medical, Health and Hospital Program of the U. M. W. A. Welfare and Retirement Fund," by Dr. Warren F. Draper, executive medical officer of the Fund, were distributed to members of the Board of Trustees at its meeting Dec. 8, 1949, and sent to members of the Committee on Medical Economics and the Commission on Industrial Health and Hygiene.

After consultation with the former chairman, Dr. Louis W. Jones, approval of two minor changes in the Veteran's Administration fee schedule was recommended to the Board of Trustees, also renewal of the V.A. agreement for one year beginning July 1, 1950.

Respectfully submitted,

JOHN T. FARRELL, JR.	PHILIP J. MORGAN
THOMAS W. MCCREARY	NORMAN C. OCHSENHIRT
EDGAR W. MEISER	WILFRED W. WILCOX
L. DALE JOHNSON, <i>Ex officio</i>	

DUDLEY P. WALKER, *Chairman*



COMMITTEE ON PUBLIC HEALTH LEGISLATION

To the President and House of Delegates:

A report of the activities of the committee during the past year may be divided into the following subheadings:

1. Federal legislation.
2. Improvement in the county medical society legislative program.

3. Legal activities.
4. Future governmental and legislative procedures concerning public health and medical care.

Federal Legislation

The outstanding bills considered by the Federal Congress during the latter part of the 81st Congress are:

S. 1679, an omnibus bill providing for Federal activities in health and medical care, including compulsory health insurance, together with certain allied bills; they are all in a Senate subcommittee and will probably not be acted upon during this session.

S. 522, providing for Federal subsidization of public health units in the various states, passed the Senate and was amended in the House Committee on Interstate and Foreign Commerce eliminating treatment. At the present writing it is on the House calendar awaiting a vote, and will no doubt pass as amended.

At the recent AMA San Francisco meeting the Reference Committee on Legislation and Public Relations disapproved this bill as presently written and so reported to the House of Delegates and the House agreed.

The 1942 House of Delegates of the AMA passed the following resolution concerning local public health units:

WHEREAS, A major inadequacy in civilian health protection in war as in peacetime continues from the failure of many states and of not less than half the counties in the states to provide even minimum necessary sanitary and other preventive services for health by full-time professionally trained medical and auxiliary personnel on a merit system basis supported by adequate tax funds from local and state and, where necessary, from Federal sources; therefore be it

Resolved, That the Trustees of the American Medical Association be urged to use all appropriate resources and influences of the Association to the end that, at the earliest possible date, complete coverage of the nation's area and population by local, county, district or regional full-time modern health services may be achieved.

S. 1411, providing for physical examination of school children and treatment to remedy defects discovered, has passed the Senate and is pending in a House committee. The AMA opposes Section C which provides for treatment of all school children whether their parents are able to pay or not. This provision should be deleted and medical care should be provided only to children of parents who are unable to pay.

S. 1453, Federal aid to medical education, has passed the Senate and is in the House committee where certain amendments presented by the AMA are being considered. These are: (1) inhibit Federal control, (2) equalize the subsidy given for old and new medical students, (3) eliminate scholarships, and (4) eliminate the provisions for additional facilities until after the AMA has made a survey of the situation. The House committee indefinitely postponed this bill. Then Mr. Biemiller of Wisconsin introduced a similar bill, *H. R. 8886*, which was postponed by the committee until August 8.

H. R. 6000, social security amendments, has been considered by the Senate committee. Physicians have been excluded and the clause providing for total and permanent disability has been eliminated by the Senate committee.

Numerous so-called "fringe" bills are still passive so far as consideration by this session of Congress is concerned.

The committee has responded to all requests to contact United States Congressmen and Senators.

It is difficult to determine how far to go with Federal subsidization through legislation because Federal subsidy means Federal control. The American Medical Association should be very careful of the bills approved providing for such subsidization.

Improvement in the County Medical Society Legislative Program

During the last session of the Pennsylvania Legislature, it was evident that the State Medical Society's influence in the Legislature was not as pronounced as it had previously been. Complaints received by the committee indicate that some physicians are not rendering satisfactory service and in some instances are overcharging. In the opinion of the legislators, this is an outstanding reason for considering the licensing of chiropractors and extending the scope of practice of other limited licensees. They feel that this will provide the public with more service.

Federal congressmen and state legislators are most susceptible to telegrams, telephone calls, letters, or any personal contact received from their own constituents. This seems to be the predominant factor in determining the action they take. Therefore, it is necessary to create a more closely knit, active organization to provide personal contacts with representatives in the Federal Congress and State Legislature in greater number than ever before.

At its meetings throughout the year, the Committee on Public Health Legislation has tried to develop such an organization. The functions of the committee have been decentralized. Each individual member is responsible for the counties in his councilor district. He is following up communications from the State Society committee to the county society committees in order that recommendations contained therein may be carried out.

We have requested counties containing more than one legislative district to supplement their committees in order to have representatives from each district.

When requested, the members of county medical society legislative committees are expected to send individual telegrams or letters or make phone calls to their Federal congressmen or state legislators regarding certain bills. We also request that they ask the members of their families and their friends to do likewise. The State Society committee will furnish all material to be used in any such communications.

The committee also believes that all state and county medical society officers and committee chairmen should be willing to help in this work. It is absolutely essential that we develop a system whereby more correspondence can be sent to representatives in the Federal Congress and State General Assembly.

Legal Activities

The legal advisors for the committee have been very active during the past year. Act 525, creating a State Board of Chiropractic Examiners, according to our legal advisors, is unconstitutional because it has no provision for powers, limitations, or privileges. They have suggested a plan whereby the act can be brought into the Supreme Court through quo warranto proceedings and the constitutionality determined. The matter at the present writing is in the hands of our attorneys and the Attorney General's office.

Intense study has been made of the election laws which include the Hatch Act and the Corrupt Practice Act. County medical societies have been notified concerning the rights of individual members during elections.

Our attorney investigated the legal status of the closed staff of the George F. Geisinger Hospital in Danville. He advised that according to the constitution and the action of the board of directors of the hospital it is a legally closed hospital so far as the staff is concerned.

The question arose as to the rights of physicians participating in the Veterans Administration medical care program during an election. It is the opinion of our attorney that such a physician is permitted to indulge in election activities except during the performance of his work, which may mean a half hour or an hour during the period he is actually examining or treating a VA patient.

Future Governmental and Legislative Procedures Concerning Public Health and Medical Care

The Joint State Government Commission is studying the following items in which the medical profession is interested:

1. A revision of the mental health code. A hearing was held before a subcommittee of the commission concerning the mental health code, at which Drs. Hilding A. Bengs, Hamblen C. Eaton, and Howard K. Petry, representing the State Medical Society, presented their comments.
2. A subcommittee was also appointed to study the entire Public Assistance program including the medical care program. The Committee on Public Health Legislation has requested an opportunity to present its views.
3. A Subcommittee on Professional Licensure has been appointed. The committee is also keenly interested in this and has offered to cooperate with the commission.

The Committee on Public Health Legislation has been authorized by the House of Delegates and the Board of Trustees to study legislation providing for local public health units and a system establishing permanency in the positions of professional employees of the State Department of Health.

Acts secured from various states on these questions are now in the hands of our legal advisor, who will draft the bills according to the constitution of Pennsylvania.

After these bills are drafted, they must be approved by the State Medical Society Board of Trustees and the

Commission on Public Health and Preventive Medicine, the State Department of Health, the governmental administration, and the Association of County Commissioners.

These bills must provide authority for the local county commissioners to levy taxes to establish and maintain their part of the health activities. Standards must be developed by the State Department of Health which will be conformed to by the counties.

The antivivisectionists are expected to be very busy during the next session of the Legislature. We must be just as active. When one considers that a group as small as the antivivisectionists can be so vocal and send in so many letters to our legislators, it is difficult to understand why 10,500 members of the State Medical Society cannot do better.

The same situation exists regarding the limited licensees, particularly the chiropractors, who will no doubt be just as active in endeavoring to obtain enabling legislation to give their board the powers they desire. Approximately 1500 members of the chiropractic group have developed an organization which sends in thousands of telegrams to our legislators. It is again a matter of deep concern to the medical profession. Some system must be developed to protect the public from these inefficiently trained practitioners.

Federal Grant-in-Aid Funds

The following table indicates the amount of Federal funds granted in the State Department of Health for the various activities:

PENNSYLVANIA DEPARTMENT OF HEALTH FEDERAL GRANT-IN-AID FUNDS

(Fiscal Year 1951)

U. S. Public Health Service—general health program	\$867,600
U. S. Public Health Service—venereal disease control	314,300
U. S. Public Health Service—tuberculosis control	311,800
U. S. Public Health Service—heart disease control	107,500
*U. S. Public Health Service—cancer control	233,700
U. S. Public Health Service—water pollution	33,700
Children's Bureau — maternal and child health services	451,965
Children's Bureau—aid to crippled children	260,604
Grand total	\$2,581,169

Your chairman wishes to express his sincere appreciation of the excellent cooperation of the county medical societies and their woman's auxiliaries, also of the

* Of this sum, \$45,000 is allocated for postgraduate training of physicians and \$10,000 for training of dentists. All this money comes through the Cancer Institute of the United States Public Health Service which has been authorized to distribute funds to approved institutions for education and cancer research work.

services of Mr. James H. Thompson, attorney for the committee.

Respectfully submitted,

JOSEPH J. TOLAND, JR.	CHARLES A. ROGERS
THOMAS L. SMYTH	WENDELL B. GORDON
WILLIAM J. CORCORAN	MILTON F. MANNING
J. STRATTON CARPENTER	HERMAN A. FISCHER, JR.
HENRY WALTER, JR.	E. ROGER SAMUEL
HIRAM T. DALE	WALTER F. DONALDSON
LUTHER J. KING	MARK K. GASS (ex officio)
HERMAN C. MOSCH, <i>Assistant to the Chairman</i>	
CHARLES V. HOGAN, <i>Vice-Chairman</i>	
C. L. PALMER, <i>Chairman</i>	



COMMITTEE ON PUBLIC RELATIONS

To the President and House of Delegates:

The committee was charged with two specific responsibilities during the past year: first, to further our long-range public relations program, and second, to promote the National Education Campaign in Pennsylvania. The committee has made every effort to extend an active interest in the long-range program, aware that unless we clarify the misunderstandings which now exist in the minds of some of the public, the National Education Campaign can never be successful.

The services of the committee's field representatives have been a decided asset to our program. They have stimulated the component county medical societies in organizing and implementing local public relations programs. The county societies have been welded into a fighting unit against the socialization of medicine.

Much can be said about the progress made during the past year and the techniques which have been used. Each county medical society can point to increased services to the people. If the status of national health legislation can be used to measure the success of our program, it is reasonable to assume that the public is more familiar with the issue of compulsory health insurance today than it was a year ago. A greater respect for the medical profession has grown out of this increased knowledge.

The committee believes that those of you who read this report have been active in the public relations program at either the state or county levels and are familiar with it. Therefore, rather than give a detailed report, we felt that you would be more interested in comparing the status of this year's results with last year's.

<i>* National Education Campaign</i>	<i>1948-49</i>	<i>1949-50</i>
Number of county societies organized	22	52
<i>* Resolution Campaign</i>		
County medical societies ..	18	53
County medical society auxiliaries	18	35
Lay organizations	46	624
Total resolutions	82	712

* The figures listed under 1949-50 represent the cumulative total of last year's records plus this year's increase.

** Campaign Literature*

Number of pamphlets distributed	1,500,000	4,300,015
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** "Your Health" Column*

Daily papers	45	52
Weekly papers	96	104
Farm magazines	4	5
Foreign language papers ..	4	4
House organs	0	3

** "Daily Dozen" Column*

Daily papers	8	10
Weekly papers	30	36
House organs	54	56
Farm journals	1	1

Radio

Stations broadcasting weekly 15-minute AMA recordings	31	43
Stations broadcasting "Your Doctor Speaking"	5	6
Stations broadcasting "Research Reporter"	0	1
Education Campaign transcription broadcasts	0	31

** Emergency Medical Call Service*

Counties with active programs	26	32
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Health Poster Contest

County medical societies and auxiliaries participating ..	19	33
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Benjamin Rush Award

County societies participating	10	22
Number of nominations submitted	13	34

Health Films

Number of showings	182	455
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Centenarian Project

Number of centenarians honored	16	23
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News Releases (cumulative total)

Papers receiving releases ..	3083	4989
Announcements of county society meetings released ..	109	99
Special event stories released	87	75
Clippings received from Central Press Bureau ..	2773	3358

(NOTE: It is estimated that our clipping service supplies us with about 50 per cent of news coverage.)

Exhibits Displayed During 1949-50

Annual convention—Pittsburgh
State Farm Show—Harrisburg
Secretaries-Editors Conference—Harrisburg
Auxiliary Mid-Year Conference—Harrisburg
Postgraduate Institute—Philadelphia

<i>Staff Activities</i>	1949-50
County society visitations	221
Talks before county societies	51
Talks before campaign committees	74
Talks before woman's auxiliaries	26
Talks before lay groups	45
Lay business conference	172

Speakers' Bureau

We cannot estimate the number of speaking engagements filled by county medical society speakers' bureaus during the past year. We do know, however, that all societies have greatly increased their activity in this field. They are being called upon to present medicine's true story to the public on the issue of compulsory health insurance, and they are rendering a valuable service in the field of health education.

Woman's Auxiliary

The committee recognizes the value of the Woman's Auxiliary in the field of public relations and has made every effort to assist the women in the promotion of their program. The services of our Harrisburg staff have been placed at their disposal. This confidence in their ability to do a job well has paid generous dividends.

For the Auxiliary's fine spirit of cooperation and assistance, the committee wishes to express its humble thanks.

Miscellaneous Activities

1. Assisted county societies in promoting special events at the local level.
2. Cooperated in publicizing articles in national magazines where Pennsylvania doctors were featured.
3. Conducted a survey of medical fraternities in Pennsylvania to enlist their support in the Education Campaign.
4. Promoted press and radio coverage of annual convention.
5. Promoted press and radio coverage of Wainright Tumor Clinic annual meeting.
6. Planned and assisted in producing two television shows.
7. Conducted one National Education Campaign Committee area conference.
8. Arranged press and radio coverage of councilor district meetings.
9. Dramatized our public relations program before the Secretaries-Editors Conference.
10. Issued regularly our "Public Relations Reporter."

Conclusion

The committee wishes to acknowledge with grateful thanks the splendid cooperation received from representatives of the press and radio during the past year. Much of the program would not have been possible without their assistance. We trust that this close liaison may be maintained and that they will feel free to call upon local county medical societies and the MSSP when they may be of service to them.

Credit for whatever success our public relations program may have attained this year is due those individual physicians in each county medical society who have given of their time and talents to implement our program at the local level. The thanks of our committee may

seem insignificant in view of the outstanding services these physicians have rendered. Nevertheless, we are confident that their reward will be measured in greater service to the community and in increased respect for the medical profession.

To the President, the House of Delegates, the Board of Trustees, and our most efficient staff, we wish to express our appreciation for the cooperation and encouragement accorded the Committee on Public Relations during 1949 and 1950.

Respectfully submitted,

Ex officio:

E. ROGER SAMUEL	JAMES M. MAYHEW
HAROLD B. GARDNER	LEO H. CRIEF
GEORGE S. KLUMP	HOWARD K. PETRY
JAMES L. WHITEHILL	FREDERIC B. DAVIES
WALTER F. DONALDSON	J. VAN S. DONALDSON
LOUISE C. GLOECKNER	SAMUEL B. HADDEN
	ARCHIBALD LAIRD
	RICHARD S. DAVIS
	ALLEN W. COWLEY, <i>Chairman</i>

COMMITTEE ON ARCHIVES

To the President and House of Delegates:

Our committee, desirous as always of acknowledging the receipt of contributions for its files that deal with records and functions of the Society and its component societies, has had a strangely sterile experience during the past year. There is nothing to report except some interesting correspondence with a representative of the Fidelity-Philadelphia Trust Company, which led to their forwarding to our committee a tin case which had come into their possession containing the "original charter of The Medical Society of the State of Pennsylvania, dated Nov. 4, 1869."

Inasmuch as the committee had very recently framed and filed away the charter issued by the courts in 1890, the announcement that a charter issued in 1869 was extant aroused considerable interest. This was soon allayed by a search of the Society's transactions, which brought out the following information which may be found on page 56, Transactions for 1869-70-71 of The Medical Society of the State of Pennsylvania, bound and in the vault at 230 State Street, Harrisburg:

"The Committee on Charter have the honor to report that, in accordance with instructions, they had the charter properly engrossed on parchment," and endorsed by the attorney general of the State on Nov. 4, 1869. "After obtaining the signatures of the incorporators residing in different parts of the State at no inconsiderable trouble," complains the committee, "the charter was presented for approval to the judges of the Supreme Court, a majority of whom ordered 'that the parties applying for the allowance of the proposed charter be permitted by counsel to appear before this court, as if on a rule, to show cause why the charter in question should not be granted.'"

The committee, properly represented by counsel, appeared before the court and when "it became evident that no such charter as would enable the Society to continue their present organization and form of government would be granted by the Supreme Court," the application was withdrawn. The committee, believing that "the Society can as at present organized administer

their affairs much more efficiently than would be possible under restricted franchises, asked to be discharged from the further consideration of the subject."

Your Committee on Archives will accept the discarded charter in its original tin case, and consider the Society fortunate in having its existing charter, which was obtained twenty years later, a photograph of which adorns the wall of an office of the Society at 230 State Street, in Harrisburg.

Persons desiring to review any of the many minutes, reports, volumes, books, or other items in the committee's care at 230 State St., Harrisburg, should communicate with the librarian. These may not be removed from the premises, but are available for study or copying. The librarian will, on request, forward to members a mimeographed list of items available. The items here referred to have been a valuable source of material in the preparation of the "History of Medicine in Pennsylvania 1848-1948," which will be available to subscribers (\$4.50) before Jan. 1, 1951.

Respectfully submitted,

ELWOOD T. QUINN CLARENCE R. PHILLIPS
WALTER F. DONALDSON, *Chairman*

COMMITTEE ON EDUCATIONAL FUND

To the President and House of Delegates:

Supplementing our committee's "preliminary report" to the 1949 House of Delegates, which included proposed rules and regulations, ten in number, governing the administration of the fund, we can report at this time that a copy of the application form designed by the committee, with appropriate information regarding Section 5 of Article IX of the Constitution, and Section 9 of Chapter VII of the By-laws of our society pertaining to the educational fund and the duties of the committee, first appeared in the December, 1949 issue of the PENNSYLVANIA MEDICAL JOURNAL. Officers and editors of county medical societies had previously been alerted to the appearance of this information, which, on a reduced scale, appeared subsequently in the January and February issues of the JOURNAL.

The application form, which is forwarded to those who make inquiry, bears all of the above-mentioned information, as well as an appropriate set of questions and provisions for letters of recommendation, reasons for applying for assistance, etc.

The date for making application for assistance in connection with the school year beginning in September, 1950, was extended to June 1.

A total of six requests for the application form were received; two were not returned, possibly because educational qualifications did not measure up to the requirement; one application was declined because in the judgment of the committee the need for financial assistance was not satisfactorily established; three were accepted. Of the latter, one will enter the freshman class in college with a program to include four years of medical college; another will enter the sophomore class in college, to be followed by medical college training; the third will enter the second year in medical college. These three accepted applicants are the sons of deceased members of our state medical society—one from a widow's family of seven other children; another from

a widow's family including three children. In each instance the secondary school records as well as the college records were of excellent quality and marked by fine grades.

Our committee, feeling its way and hoping to profit by experience, has placed a limit on the amount of financial assistance to be given during this first year. We are happy to report that in each instance these young men have secured summer employment and are of the type who will help themselves. In pledging assistance to these students as long as each previous year's work justifies continued assistance, your committee realizes that the total amount involved in each of two approved applications may approach seven or eight thousand dollars.

Respectfully submitted,

M. LOUISE C. GLOECKNER ELMER HESS
WALTER F. DONALDSON
JAMES L. WHITEHILL, *Chairman*

COMMITTEE ON NECROLOGY

To the President and House of Delegates:

It is again our sad duty to report the death of 163 members who have departed from our ranks since our last session. We earnestly pray to our Heavenly Father to intercede in their behalf, overlook any shortcomings they may have had, and grant peace and support to their bereaved ones.

It becomes more and more apparent as the years pass by that greater courage, stamina, and preparedness are necessary to meet the trying obligations we must face. May we who remain be granted the strength to carry on in the same manner as did our predecessors.

A tabulation of the ages of our deceased members will be found interesting, the youngest being aged 27 and four members between the ages of 90 and 93. Six members were between 35 and 40 years of age; 10 in their forties; 23 between 50 and 60 years; 40 between 60 and 70 years; 56 between 70 and 80 years; 18 between 80 and 85 years; and 5 between 85 and 90 years of age. The names of our deceased members are published month by month in the PENNSYLVANIA MEDICAL JOURNAL and in the annual Roster of the Society; therefore, they will not be named in this report.

Respectfully submitted,

WALTER F. DONALDSON FRANCIS S. MAINZER
HERMAN A. GAILEY HUGH R. ROBERTSON
M. FRASER PERCIVAL, *Chairman*

COMMITTEE ON MEDICAL BENEVOLENCE

To the President and House of Delegates:

During the past twelve months the Medical Benevolence Committee gave financial assistance to 28 direct beneficiaries. Of these, twelve were widows of former members without dependents, six were widows with dependent children, and eight were aged or incapacitated physicians; two were daughters of deceased members. One beneficiary was approved for temporary financial assistance only. During the year one beneficiary died;

one was discontinued, having been admitted to a fraternal home; the quarterly benefit to one beneficiary was increased, and three new beneficiaries were added.

Contributions from the Woman's Auxiliary for the fiscal year totaled an all-time high of \$10,248.77. Of that amount, \$125 represented the net proceeds from the sale of the cook book prepared by the Cook Book Committee of the Woman's Auxiliary to the Lehigh County Medical Society. Additional contributions of \$125 were received from four members of the State Medical Society, two of which were "memorial" contributions.

Included in the contributions from the Woman's Auxiliary were memorials from individuals and from county society auxiliaries to: Mrs. J. R. Gormley, Mrs. Bruce Snodgrass, Mr. M. R. Glover, Dr. E. W. Boots, Mrs. C. H. Muhlenberg, Mrs. Fry, Dr. A. H. Bauscher, Dr. James E. Cochran, Mrs. A. Harvey Simmons, Dr. J. B. Mosser, Dr. Fairfax G. Wright, Dr. Clark M. Smith, Mrs. James Blackwood, Tom Smith, Dr. W. A. Hausman, Mrs. Slotterer, Mrs. H. M. Johnston, Mr. C. Bean, Miss Mayhew, Mrs. Lyda Helsel, Mrs. S. W. Selten, Mrs. W. H. Walters, Mrs. Henry Dirschedl, and Mrs. Miriam McMurray.

The total also includes contributions in honor of Mrs. Drury Hinton and Dr. J. A. C. Clarkson.

The interest of the members of the Woman's Auxiliary in the medical benevolence fund continues unabated year after year and the Medical Benevolence Committee again wishes to commend them and express gratitude for their help.

As evidence of the appreciation of the assistance rendered by the medical benevolence fund, we quote from a letter received from a member of the State Society who receives and turns over to one of the committee's more recent beneficiaries the quarterly payments from the benevolence fund:

"One of the real pleasures of my recent years came two weeks ago when I gave Mrs. _____ the first payment of the amount allotted to her from the medical benevolence fund. The sincere gratitude she felt and expressed when I told her that she would receive a monthly remittance was well worth any effort spent in arranging it."

A detailed report of contributions to the Benevolence Fund will be found in the financial report of the Secretary-Treasurer of the State Society, which will be published in the September issue of the JOURNAL.

The report of the treasurer of the Medical Benevolence Committee's fund follows:

Balance on hand Sept. 1, 1949 \$21,456.66

RECEIPTS

Contributions from woman's auxiliaries	\$10,248.77
Contributions—miscellaneous	125.00
Interest on deposits and investments	5,830.30
	16,204.07
	\$37,660.73

Disbursements to beneficiaries \$14,385.00

Balance on hand Sept. 1, 1950 \$23,275.73

Respectfully submitted,

LAURRIE D. SARGENT
FRANCIS J. CONAHAN, *Treasurer*
WALTER F. DONALDSON, *Secretary*
E. ROGER SAMUEL, *Chairman*



ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

To the President and House of Delegates:

The Woman's Auxiliary having passed its quarter century mark has attained adult status and has acquired the experience which makes less frequent its demand for directive advice from your advisory committee. On the other hand, its increasing activities in the fields of public relations and public health legislation and its generally aggressive program pose problems whereby individual conference and suggestion are frequently sought.

Your committee has not met during the year, but the members of it have conferred with the officers of the State Auxiliary, offering suggestions, approving programs, and helping to direct the activities of this organization.

As a committee we wish to pay tribute to the zealous performances of duty by the officers of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania. They have been tireless in their efforts and have accomplished much to aid the Medical Society in its program. In addition, they have shown an unusual cooperative spirit and a willingness to accept suggestion and direction in their activities in these fields. For many years there was a feeling that the Woman's Auxiliary function was social and many competent doctors' wives found little stimulation in its work. This is rapidly changing and the Woman's Auxiliary is now becoming a powerful aid in the extraprofessional program of the Medical Society. Because of the extraordinarily cooperative spirit on the part of the officers of the Auxiliary, service on this committee is one of the very happy experiences that can come to a member of The Medical Society of the State of Pennsylvania.

Respectfully submitted,

DRURY HINTON

FRANCIS P. DWYER
HOWARD K. PETRY, *Chairman*



COMMITTEE ON HOSPITAL RELATIONS

To the President and House of Delegates:

No problems have been reported to the Committee on Hospital Relations this year; therefore, there is nothing to report.

The committee will meet in Philadelphia, in October, during the 1950 State Society meeting to conduct any business that may be on the agenda for it at that time.

Respectfully submitted,

LOUIS E. AUDET	CHARLES L. JOHNSTON
WILLIAM BATES	THOMAS W. MCCREARY
WILLIAM F. BRENNAN	PAULINE K. WENNER
	ELMER HESS, <i>Chairman</i>

COMMITTEE ON MILITARY AFFAIRS

To the President and House of Delegates:

The committee has had no function to perform during the year and consequently has no report of activities to submit.

We believe, however, and *we urgently restate our belief as presented last year*, that a committee on military affairs of a state medical society should have an *assigned function*, provided that it be the same or a similar function in every state medical society, and provided that this function is integrated at the top with that of such a committee of the American Medical Association, and in each state with the function of a committee on military affairs in each county medical society.

A major function that such an organization of committees could perform is the preparation and annual revision of a list of county medical society members from the standpoint of their probable availability or non-availability for service in case of war or major disaster. Those in the same county could best gather and keep up to date such information about physicians as their age, professional skill, training, and certification, teaching and institutional connections and consequent status of availability, linguistic ability, previous foreign sojourn, marital and familial status, obvious physical incapacity, present affiliation with and experience in a military establishment, etc. The function of such an organization of committees could also be integrated with the function of those charged with the preparation of civilian defense.

The experiences during the recent war offered ample proof that during such an emergency the medical profession is called upon to perform greater service as a group than is any other segment of our population. Therefore, as a profession, we should make every effort to implement and carry out the program here proposed in order that the most efficient use can be made of medical personnel in time of emergency.

Respectfully submitted,

CONSTANTINE P. FALLER JAMES M. HENNINGER
GERALD N. FLUEGEL EDWARD LYON, JR.
RICIARD A. KERN, *Chairman*

COMMITTEE ON PSYCHIATRIC SERVICES TO CRIMINAL COURTS

To the President and House of Delegates:

Inasmuch as the Legislature was not in session, the committee was relatively inactive the past year. Various legislators have been interviewed by the chairman and members of the committee regarding a bill to establish psychiatric clinics for the criminal courts of the various counties. It will be remembered that during the past two sessions of the Legislature similar bills were not passed. There is every hope that such a bill will become law at the 1951 session of the Legislature.

The committee chairman attended two joint meetings of the Medico-Legal Committee of the Pennsylvania Bar Association and a similar committee of the Pennsylvania Psychiatric Society, at which meetings various

plans and legislative procedures for the proper management of psychopaths were discussed.

The committee desires and recommends continuance.

Respectfully submitted,

FREDERICK H. ALLEN RODNEY H. KIEFER
FREDERICK S. BALDI LEROY M. A. MAEDER
ROBERT H. ISRAEL PHILIP Q. ROCHE
HERBERT H. HERSKOVITZ, *Chairman*

COMMITTEE ON RURAL MEDICAL SERVICE

To the President and House of Delegates:

Pennsylvania Health Council

Under the auspices of the committee, the Pennsylvania Health Council, Inc., has been organized this year. At a meeting on February 8 the following officers were elected:

Dr. Gilson Colby Engel, president
Dr. C. Howard Witmer, vice-president
Mrs. Philip S. Broughton, vice-president
William G. Mather, Ph.D., secretary
Mr. Edward M. Green, treasurer

Four committees have been appointed: Committee on Budget and Finance—Dr. Lewis T. Buckman, chairman; Committee on Membership—Mr. John H. Bidle, chairman; Committee on Program—Dr. C. L. Palmer, chairman; and Committee on Public Relations and Education—Mr. George E. Reimer, chairman.

By-laws for the Health Council have been distributed to all the member organizations, and published in the May PENNSYLVANIA MEDICAL JOURNAL.

On June 12 the Pennsylvania Health Council, Inc., received its charter and is ready to proceed in an official manner as to the program it adopts.

Review of Activities

The Committee on Rural Medical Service maintains a list of communities which have indicated the need for a physician. One of the earliest activities of the committee was consideration of these communities. Some were eliminated because of personal knowledge of members of the committee that the community was not able to support a physician or did not need one. The committee continues to try to supply physicians in communities where they are needed.

The committee in its deliberations on the question of rural medical care is always guided by suggestions from the AMA Committee on Rural Health. In its earliest meetings, after its organization, the committee decided on the following points concerning rural health:

1. To attract young physicians to rural areas, public health centers must be developed where needed. This comes under Public Law No. 725, the Hospital Construction Act.

2. Communities must improve their economic, educational, and general sanitary conditions.

This will be the function of the Pennsylvania Health Council, which will form local county and community councils for the purpose of studying the health and sanitary needs.

3. Individuals in rural areas who understand and enjoy rural life should be encouraged to study medicine.

The members of the committee decided they would try to interest young people in their various communities to study medicine.

Respectfully submitted,

MILTON F. MANNING
ORLO G. McCOY

LUTHER Q. MYERS
MORGAN D. PERSON
C. L. PALMER, *Chairman*

COMMITTEE ON WORKMEN'S COMPENSATION LAWS

To the President and House of Delegates:

Since the Pennsylvania Legislature was not in session this year, no bills have been considered by the committee.

The committee will look to the next session of the Legislature, bearing in mind some of the items mentioned in the report of the Committee on Workmen's Compensation Laws to the 1949 House of Delegates of The Medical Society of the State of Pennsylvania.

Here it was emphasized that Pennsylvania remains one of the backward states in the nation as far as workmen's compensation is concerned. About half the states, including other industrial states, provide unlimited medical and hospital care.

The Society should realize that, with the funds being requested by labor, its approach will be to improve the physical condition of the workers and develop vocational rehabilitation for those workmen who have injuries resulting in temporary or permanent disability.

If these programs increase in extent and intensity, the whole fabric of our workmen's compensation system will have to be studied in order to liberalize it if it is to continue.

The committee therefore believes that political leaders should be informed of the activities under these so-called welfare funds and some effort made to liberalize workmen's compensation in order to preserve the well-founded system which has been in existence since 1915 in this state.

Respectfully submitted,

EARL F. HENDERSON
JOHN C. HOWELL

LOYAL A. SHOUDY
SCOTT A. NORRIS
PARK A. DECKARD, *Chairman*

COMMITTEE ON TELEPHONE DIRECTORY CLASSIFICATION

To the President and House of Delegates:

Your committee reports attaining its objective in keeping unencumbered the telephone listings of our profession throughout the Commonwealth from those of cultists who desire the prestige of riding on the coat-tails of the doctors of medicine. The Bell Telephone Company of Pennsylvania continues to serve us well. We extend to them our thanks and appreciation.

Respectfully submitted,

RICHARD J. CAMPION
ERNEST W. LOGAN
T. ILMAR WILLIAMS, *Chairman*

REPORTS OF COMMISSIONS AND SPECIAL COMMITTEES

COMMITTEE TO STUDY THE RECOMMENDATIONS OF PAST PRESIDENT GILSON COLBY ENGEL

To the President and House of Delegates:

Your committee met in Harrisburg, Jan. 28 and 29, 1950, to consider the recommendations of President Gilson Colby Engel to the 1949 House of Delegates concerning the general committee setup of The Medical Society of the State of Pennsylvania. At this meeting the suggestions of Dr. Engel were thoroughly discussed, but it was deemed necessary to have further consultation with other members of the State Medical Society. After this meeting was adjourned the committee selected various members and asked them to file their opinion of the suggested changes in writing with the chairman.

After reviewing these reports, the committee again met in Harrisburg, April 15 and 16, for hearings on Dr. Engel's recommendations. The chairmen of various committees and officers of The Medical Society of the State of Pennsylvania were asked to appear. Drs. C. L. Palmer, James L. Whitehill, Dudley P. Walker, Allen W. Cowley, and Mr. Lester H. Perry, executive secretary, were present.

Following appropriate discussions concerning the establishment of a Disease Control Committee, the following conclusions were reached:

1. It was agreed that this committee should recommend to the House of Delegates the establishment of a Disease Control Committee.

A. That this committee should consist of the chairmen of the following committees:

Commission on Acute Appendicitis Mortality
Commission on Cancer
Commission on Child Health
Commission on Conservation of Vision
Commission on Deafness Prevention and Amelioration
Commission on Defense of Medical Research
Commission on Diabetes
Committee on Emergency Disaster Medical Service
Commission on Graduate Education
Commission on Industrial Health and Hygiene
Commission on Laboratories
Commission on Maternal Welfare
Commission on Mental Hygiene
Commission on Nutrition
Advisory Committee to Pennsylvania Board for Vocational Rehabilitation
Commission on Physical Medicine and Rehabilitation
Commission on Preventive Medicine and Public Health
Commission to Study Control of Syphilis and Venereal Diseases
Commission to Study Control of Rheumatic Fever
Commission on Tuberculosis

- B. That the secretary-treasurer of the State Society should also be a member of this committee.
 - C. That the president of the State Society should be the chairman of the committee.
 - D. That a representative of the State Health Department should be a member of this committee, this representative to be a doctor of medicine licensed in the State of Pennsylvania, who is a member of The Medical Society of the State of Pennsylvania.
 - E. That the function of this committee shall be to study and coordinate the activities of the commissions and committees under Section A.
 - F. That this committee shall have at least two meetings each year, one to be held during the annual convention of the MSSP and the other to be held during the Secretaries and Editors Conference. Other meetings may be held at the call of the president.
2. It was agreed that a special committee should be established by the House of Delegates to be known as the Policy Coordinating Committee:
 - A. That the membership of this committee shall be the chairmen of the Committees on Public Health Legislation, Public Relations, and Medical Economics, the secretary-treasurer of the MSSP, and the president of the MSSP, who shall be the chairman.
 - B. That the meetings of this committee shall be held before each regular meeting of the Board of Trustees at the call of the president. Special meetings may be called at any time by the president or the chairman of any one of the three committees.
 - C. That the function of this committee shall be to study, coordinate, and evaluate the activities of the Committees on Public Health Legislation, Public Relations, and Medical Economics.
 3. It was the consensus of opinion that the establishment of these two committees—Disease Control Committee and Policy Coordinating Committee—would not require changes in the Constitution and By-laws, in view of the fact that these committees would become special committees, effective when the recommendations are accepted by the House of Delegates.

Respectfully submitted,

HENRY F. HUNT AUGUSTUS S. KECH
HERMAN A. FISCHER, JR. THEODORE R. FETTER
 THOMAS W. MCCREARY, *Chairman*

COMMISSION ON ACUTE APPENDICITIS MORTALITY

To the President and House of Delegates:

The report of the 1947 survey of acute appendicitis in Pennsylvania will be published in the October, 1950 PENNSYLVANIA MEDICAL JOURNAL. The delay has occurred because of the development and initiation of a plan for the eradication of deaths from spreading peritonitis in Pennsylvania. The Pennsylvania Department of Health and the Department of Welfare are collaborating with the State Medical Society and our commission.

Although it is still evident from the following table that prevention of the ruptured appendix is the only way to wipe out deaths from appendicitis peritonitis, the new plan will help to save some of those who have not yet been reached by the prophylactic campaign.

SPREADING PERITONITIS

<i>Year</i>	<i>Number of Cases</i>	<i>Number of Deaths</i>	<i>Mortality Per Cent</i>
1937	2342	608	25.96
1942	566	233	41.17
1947	320	160	50.00

The 1947 survey shows that the number of cases of spreading peritonitis was greatly reduced but the mortality was at a new high.

Continuation of a Commission on Acute Appendicitis Mortality is advised.

Respectfully submitted,

FREDERICK A. BOTHE	CHARLES L. YOUNGMAN
RAYMOND J. GARVEY	HUGH R. ROBERTSON
CHARLES V. HOGAN	WILLIAM L. BROHM
HARVEY F. SMITH	LEO D. O'DONNELL
JAMES Z. APPEL	JOSEPH P. REPLOGLE
ENOCH H. ADAMS	LACHLAN M. CATTANACH
	JOHN O. BOWER, <i>Chairman</i>
	CECIL F. FREED, <i>Co-chairman</i>

COMMISSION ON CANCER

To the President and House of Delegates:

The commission devoted major effort during the past year to the formulation of comprehensive policies and the crystallization of an effective program for the control of cancer. After detailed study by the Objectives Committee, twenty projects were presented to the commission for immediate action. These projects were subsequently delegated to appropriate committees for further practical evaluation and disposition.

The Coordinating Committee's primary function is the coordination of all cancer agencies at state, district, and county levels. The committee is comprised of representatives of three state agencies and the Philadelphia agencies. Three representatives are members of the commission—one, the chief of the Division of Cancer Control, State Department of Health, and two members each from the Philadelphia and Pennsylvania Divisions of the American Cancer Society. The district cancer coordinating committees are comprised of the district representative of the commission, the district medical councilor of the American Cancer Society, chairmen of cancer committees of component county medical societies, and captains and presidents of county units of the American Cancer Society. The coordinating committee held a number of meetings and its accomplishments have been such as to warrant the commission's commendation (May 8, 1950).

The Committee on Education has under consideration or has put into effect: (1) appropriation of Federal funds such as will be made by the National Cancer Institute upon recommendation of its advisory council and approval by Surgeon General Scheele of the U. S. Public Health Service for cancer education in Pennsyl-

vania medical schools; (2) publication of a cancer manual, pamphlets, and brochures dealing with the early recognition and treatment of cancer; (3) establishment of special courses in cancer together with financial assistance to physicians while in training; (4) incorporation of examination questions on cancer by state medical and dental boards; (5) control of the sale of patent or compounded medicines to cancer patients by pharmacists; (6) elimination of the cancer quack; (7) the mailing of the *Cancer Bulletin* to all physicians in the Commonwealth through funds acquired for subscriptions from the State Department of Health and for express, handling and postage from The Medical Society of the State of Pennsylvania; (8) a full page of cancer data, paid for by the American Cancer Society, published in each issue of the PENNSYLVANIA MEDICAL JOURNAL.

The Committee on Cancer Detection Examinations during the past year has endeavored to interest the members of The Medical Society of the State of Pennsylvania in making cancer detection examinations in their offices or in cancer detection centers. For this purpose a minimum standard examination form was prepared and distributed; 1142 summary cards reporting findings of these examinations have been returned. Practically all of these came from doctors working in cancer detection centers. Less than 20 were received from private practitioners. Fourteen cases of cancer were discovered in the 1142 examinations, or 1.2 per cent. Conditions predisposing to cancer were found in 264 examinees, or 23 per cent.

The lack of interest displayed by the general practitioner led the committee to conclude that the examination requested was too elaborate. As a result, a simplified, 5-point examination form has been prepared in which the examination is limited to the five most frequent sites of cancer—the skin, oral cavity, breast, pelvis, and rectum. The committee is convinced that the general practitioner has the most important role in the detection of early cancer, and will continue to make every effort to interest him in making the 5-point cancer detection examination.

The Committee on Standards considers its primary function at the present time to be the evaluation, for the guidance of the practitioner of Pennsylvania, of the newer and incompletely tested methods of diagnosing and treating malignant disease. For example, only by thorough study and evaluation can the limitations of usefulness of Huggins' iodo-acetate index be defined. Similarly, many more recent diagnostic "tests" have been devised and others, which antedate Huggins' work, have been repopularized since Huggins' conservative scientific publications have received such widespread publicity in the lay press. The same is true of certain recent therapeutic suggestions which, by uncontrolled use or abuse, may be productive of great harm. The committee has the further responsibility of regulating such time-tried and accepted methods of therapy as radium, and roentgen rays, with the objective of preventing unskilled or unqualified individuals from employing these modalities which may inflict harm rather than the desired beneficial result.

The Committee on Tumor Clinics is primarily responsible for the reorganization of the Wainwright

Tumor Clinic Association of Pennsylvania, which was accomplished, after a year of effort, in April, 1950. In accordance with the recently revised constitution and by-laws, officers and directors were elected at the annual meeting in Johnstown, April 13. It is now the objective of the committee to increase the number of tumor clinics in Pennsylvania, to revive the educational value of the association, and to materially increase its membership. With the cooperation of the commission, the Division of Cancer Control, the American Cancer Society, and the American College of Surgeons, it is anticipated that a full-time field representative and public relations consultant may be provided who will assist in the planning, organization, standardization, and inspection of clinics.

The Committee on the Care of the Advanced and/or Medically Indigent Cancer Patient, after a gratifying meeting with the State Secretary of Health, Dr. Norris W. Vaux, reported the Secretary's complete understanding of the problem and his offer to take appropriate steps to introduce legislation for an appropriation of \$750,000 to \$1,000,000 for the next biennium, these funds to be used for the purpose recommended. Rather generous publicity was given this project through the office of the Public Relations Committee of The Medical Society of the State of Pennsylvania.

The Committee to Review the Health Survey Report, "Keystones of Public Health for Pennsylvania," made a comprehensive study of the chapter on "Cancer Control" and critically analyzed the subject. It concluded that the impression is created that the Division of Cancer Control should take a more active and leading part in the cancer program within the State. The concept is also implicit that cancer is a public health problem and as such should be the responsibility of the State. It is apparently of no relevance that cancer is not contagious and its occurrence affects the private welfare rather than the public welfare. The report is a challenge to Pennsylvanians who believe the individual and the group can solve their own problems with the valued help of government in certain well-defined aspects of those problems.

Government should supplement not supplant the efforts of private citizens.

The Committee on Research has functioned during the past year at the request of various county units of the American Cancer Society in evaluating certain proposed research projects for which financial support has been sought from the American Cancer Society. Such evaluations have not infrequently necessitated the solicitation of advice from experts outside the commission. Research on environmental and occupational cancer is being continued in the State Department of Hygiene.

The inspirational cooperation of the State Department of Health and its Division of Cancer Control with the Commission during the past year merits the highest commendation. Important projects of the Division, which have been approved by the commission, include post graduate education of physicians and dentists, grants for special cancer research, the promotion of and financial assistance to tumor clinics, the collection and coding of cancer statistics, and the maintenance of a central tumor registry. In accordance with a regulation

passed by the State Advisory Health Board about ten years ago under State legal authority, cancer is a reportable disease by regulation rather than by legislation. Great effort is being expended to increase the number of reports from physicians who are indifferent to the requirement through simplification of report forms and the encouragement of voluntary reporting from hospitals.

Other important committees, such as the Budget Committee and the Speakers' Bureau, continue to function efficiently and effectively, a circumstance which makes for a most congenial and gratifying development of the commission's intensive program.

Finally, your Commission on Cancer is contributing unitedly and faithfully in the highest professional tradition to the public interest in a campaign against cancer, only the highlights of which effort can possibly be cited in the present annual report.

Respectfully submitted,

JOHN L. ATLEE, JR.	DAVID W. HUGHES
RALPH D. BACON	EDWARD LYON, JR.
DANIEL H. BEE	CATHARINE MACFARLANE
JOHN V. BLADY	STANLEY P. REIMANN
JAMES BLOOM	WESLEY D. RICHARDS
LEROY E. CHAPMAN	RUSSELL B. ROTH
MAURICE G. DINBERG	ANDREW J. WATERWORTH
GEORGE A. HAHN	J. WILLIAM WHITE
GEORGE W. HAWK	H. FRED MOFFITT
ROBERT C. HORN, JR.	

S. GORDON CASTIGLIANO, *Chairman*

COMMISSION ON CHILD HEALTH

To the President and House of Delegates:

The commission has continued to work diligently during the past year for the best interests of child health in our Commonwealth.

We are pleased to report that several projects which were initiated last year have been successfully completed. One of these is the action of the State Department of Health in including with future birth certificates sent out from Harrisburg small printed slips reminding mothers of the advisability of routine immunizations during infancy. Another was the acceptance by the State Board of Medical Education and Licensure of a revised rotating intern schedule calling for a minimum of four weeks of pediatric training, as well as that body's acceptance of the commission's suggestion that the pediatric part of the State Board examinations be given greater emphasis in view of the important part played by pediatrics in general practice.

For the same reasons, the commission views with alarm the division of the Committee on Scientific Work of the State Society into two general sections, Medicine and Surgery, with pediatrics as a subdivision of internal medicine; this tends to remove pediatrics from its generally recognized place as one of the four major clinical branches of medicine.

Despite the fact that, through the fine cooperation of the members of that committee these past two years, a goodly number of papers on pediatric subjects have been included in the programs, it is the feeling of the commission that pediatrics should be formally recognized either by changing the Section on Medicine to one

on Medicine and Pediatrics, with co-chairmen representing the two separate branches, or by creating a third section on pediatrics, and the best means of bringing about a full consideration of such a change are being diligently studied.

The commission also noted with regret the omission of pediatrics from the list of courses included in the five-year program of the Graduate Education Institute and has respectfully petitioned the Commission on Graduate Education to give further consideration to the need for inclusion of more pediatrics in any program planned for the postgraduate education of the general practitioners who care for 75 per cent of the children of our nation.

At the request of the Board of Trustees and Councilors, the commission was asked to review the chapters on (1) Maternal and Child Health and (2) School Health of the survey report entitled "Keystones of Public Health for Pennsylvania." After careful review these sections were approved in essence, and this approval was reported to the Commission on Preventive Medicine and Public Health, which was considering the report as a whole.

As the commission's representative on the Governor's Advisory Citizens' Committee on the White House Conference on Children and Youth, the chairman has attended several meetings of the county and state groups furthering this important project.

In view of the interest and activity shown by all members of this commission, it is the suggestion of the chairman that the three members whose terms of appointment expire this year be reappointed for another three-year term.

It is also suggested that the close relationship between pediatrics and general practice might be further enhanced by the appointment of one or two additional members of the commission from the ranks of the general practitioners.

Respectfully submitted,

PHILIP S. BARBA	C. BERNARDIN QUINN
WILLIAM W. BRIANT, JR.	ELEANOR R. STEIN
NORBERT D. GANNON	ELWOOD W. STITZEL
JOSEPH A. GILMARTIN	RALPH M. TYSON
	CARL C. FISCHER, <i>Chairman</i>

COMMISSION ON CONSERVATION OF VISION

To the President and House of Delegates:

The commission wishes to report that the glaucoma program instituted several years ago by Dr. Josiah F. Buzzard is still being kept active. Glaucoma was one of the subjects in the curriculum of the State Society's Graduate Education Institute, and the importance of early diagnosis from the point of view of the general practitioner was stressed.

The commission has been interested in ascertaining the most reliable prophylactic medicament for ophthalmia neonatorum. Sulfa drugs and the antibiotics have been carefully tested and compared with silver nitrate by several large clinics. It is the conclusion of the State Department of Health that the use of silver nitrate shall be continued as the accepted procedure.

Dr. Jay G. Linn, of our commission, was one of the discussors of a major paper on this subject, and his conclusions were: (1) that the silver nitrate routine is more practical for general usage because only one instillation is required, (2) that frequent preparation of solutions is not necessary when the waxed ampules containing the drug are used. The State has issued the following regulation: "It shall be the duty of physicians and midwives attending women in confinement to instill in each eye of the newborn child, as soon as practicable after birth, 1 per cent silver nitrate in solution."

A meeting of the commission was held in Chicago during the October meeting of the American Academy of Ophthalmology and Otolaryngology. The major topic for discussion was the prevention of damage to the eyes of children and adults from dangerous toys and home accidents. B B guns, toy bows and arrows, darts, pointed scissors, etc., have caused loss of vision to many children throughout Pennsylvania every year.

During the past, several attempts were made to have the State Legislature pass laws to bring dangerous toys under adequate control—similar to the fireworks law which was passed. Thus far all attempts have been unsuccessful. Many eyes have been lost in Philadelphia from injuries sustained from dangerous toys. Dr. Carroll R. Mullen, of Philadelphia, with the cooperation of *The Philadelphia Inquirer*, put on a campaign against B B guns and was successful in obtaining legislation prohibiting their use and sale in Philadelphia.

Our commission has enlisted the aid of the Pennsylvania Association of the Blind with its thirty-one branches in getting this program underway. We are now collecting statistics which will accurately tell us the principal accidental causes of loss of vision to the eyes of children. Armed with figures, the commission will be able to attack the problem at its roots.

A well-attended meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology was held in May, at Bedford Springs Hotel. The commission held a business meeting during this convention with all members but one in attendance. Some of the best men in the country were secured as lecturers for the three-day meeting. We should like to urge all practicing ophthalmologists and otolaryngologists to attend this annual meeting.

Respectfully submitted,

PAUL C. CRAIG	JAY G. LINN
GILBERT L. DAILEY	JOHN B. McMURRAY
GEORGE F. J. KELLY	JOSIAH F. BUZZARD
	WARREN C. PHILLIPS, <i>Chairman</i>

COMMISSION ON DEAFNESS PREVENTION AND AMELIORATION

To the President and House of Delegates:

Our commission is marking time and has been largely inactive this year, no issues having arisen for its consideration.

However, it seems advisable to have a standby committee to which problems may be referred, if they arise. Already there is considerable lay interest in the problem of deafness.

The Pennsylvania Department of Public Instruction is handling the deaf child problem thoroughly, but the technique of educating the hard-of-hearing child, especially in rural communities, has not been solved, and the national program of the American Academy of Ophthalmology and Otolaryngology has never matured. Your committee has been waiting to cooperate with it.

At present, there are no projects in view.

Respectfully submitted,

SAMUEL T. BUCKMAN	JAMES E. JAMES
EDWARD H. CAMPBELL	CLINTON J. KISTLER
FRANCIS W. DAVISON	JAMES E. LANDIS
KENNETH M. DAY	THOMAS B. MCCOLLOUGH
ROY DECK	JOHN R. SIMPSON
	DOUGLAS MACFARLAN, <i>Chairman</i>

COMMISSION ON DEFENSE OF MEDICAL RESEARCH

To the President and House of Delegates:

During the past year the commission busied itself primarily with matters having to do with improved public relations and support. Generally speaking, it would appear that much ground has been gained in favor of animal experimentation and research. Although the important part played by animals in the promotion and advance of scientific medicine is clearly established and more widely recognized, the use of unwanted, stray, impounded dogs and cats from the public pounds, animals much needed in the furtherance of medicine, is still actively opposed by antivivisection groups, and, unfortunately, through misrepresentation and falsification they influence individuals ill informed.

A survey indicates, however, that despite the efforts of antivivisection societies, their membership is greatly outnumbered by those of different faith, those who admit and proclaim that the advances in the medical sciences, in the knowledge of drugs, and in the diagnosis of diseases and their better treatment in recent years, whether directly or indirectly, have been made possible through laboratory studies on living animals.

While it is encouraging to have the majority on the side of scientific medicine and research, it must be said, nonetheless, that up to recent times smaller groups opposing medical progress have been more vocal in their efforts than have those who wish medicine to continue in its forward march, this through animal experimentation. With this in mind the members of the commission felt that the best that could be done between the legislative sessions was to attempt to build up better public relations, especially to try to activate groups already organized in other work to aid in proclaiming the truth concerning animal experimentation. To this end county medical societies, woman's auxiliaries to county medical societies, other groups and auxiliaries, and the cancer forum were addressed.

Appreciation is expressed to the Woman's Auxiliary to The Medical Society of the State of Pennsylvania for including in the program of its fourth annual conference a morning session, March 10, 1950, devoted to the cause of animal experimentation. The session was well attended by members from all parts of the State. Mr. Leo E. Brown, executive assistant to the Committee on Public Relations of the State Medical Society,

and Mr. Ralph A. Rohweder, executive secretary of the National Society for Medical Research, were the listed speakers. They presented the problems involved in a splendid and informative manner. Your chairman also happened to be present at this meeting and was afforded an opportunity to address the assemblage briefly.

The members of the Commission on Defense of Medical Research were invited to attend a meeting of the Planning Committee of the Woman's Auxiliary to the State Medical Society for animal research at the Penn-Harris Hotel, Harrisburg, on the afternoon of March 10. Dr. John H. Harris and your chairman attended this meeting. The chairman of the State Society's Committee on Public Health Legislation, Dr. C. L. Palmer, also attended the conference and participated in the discussion. The meeting had to do with preliminary work in anticipation of possible legislative activities in 1951.

It must be recalled that we cannot approach the problem of legalizing the use of unwanted stray dogs and cats from the public pounds of the State at a city level, as was successfully done lately in Cleveland, Baltimore, and Buffalo. In Pennsylvania there is a clause in the state agricultural law which prohibits the use of dogs for experimental work from any public pound. Since a city ordinance cannot supersede an existing state law, it will be necessary to initiate legislation at the state level. Senate Bill 278, which was introduced during the 1949 legislative session, passed two readings in the Senate and was then recommitted. It was a highly worthy and equitable bill and should serve as a pattern again.

The bill referred to above was written as an act "to establish regulatory measures and licensure for stated institutions and to make available to such institutions for scientific investigation, experiment, or instruction unclaimed and unredeemed dogs and cats impounded in public pounds in any city, county, borough, or township within the Commonwealth." All investigators and teachers using unredeemed, stray impounded dogs and cats were to be licensed, and the licensing authority was to be the Department of Health of the Commonwealth. Stray impounded dogs and cats could not be released until ten days had elapsed. The licensing authority was to be directed to appoint an advisory committee consisting of two representatives of the licensed institutions, two representatives of the Society for the Prevention of Cruelty to Animals, and two representatives of the general public. The licensing authority was to be given the right to inspect or investigate in person or by agent or agents any institution to which a license was granted.

While a survey would appear to indicate that the conditions under which animal experimentation is conducted in the several laboratories of the State is generally satisfactory, the Commission on Defense of Medical Research would ask that all animal quarters, the preoperative and postoperative care of animals, and the general oversight be checked again by those in authority in individual laboratories for possible improvements. Attention to this matter may favorably influence legislation.

Respectfully submitted,

JOHN H. HARRIS
CAMPBELL MOSES

CALVIN M. SMYTH, JR.

J. PARSONS SCHAEFFER, *Chairman*

COMMITTEE ON EMERGENCY DISASTER MEDICAL SERVICE

To the President and House of Delegates:

The committee held two meetings during the interim and it is anticipated that an additional meeting will be necessary before October, 1950. Several interim reports have been presented to the Board of Trustees and Councilors, one of which was published in the May issue of the PENNSYLVANIA MEDICAL JOURNAL.

In 1948 the Governor requested that our society organize a Committee on Emergency Disaster Medical Service, and thus this committee was inaugurated. The purpose was to coordinate efforts and cooperate with the Governor's Committee on Emergency Disaster Medical Service by making plans to care for the sick and injured during times of disaster, such as floods, fires, etc. During this year the Governor also appointed a Committee on Civil Defense of which the chairman is the Hon. Vincent A. Carroll, Philadelphia. This committee is primarily interested in preparing for emergencies such as enemy attack and atomic bombing. We also have been asked to cooperate with this committee whose executive director is Colonel Lewis F. Acker.

At the present time we are attempting to implement the program recommended by the AMA Council on Emergency Disaster Medical Service through the cooperation of the Governor's Civil Defense Committee. This consists of outlining a plan for action in the event of an atomic bombing, and also the education of the profession and laity on the medical aspects of atomic attack.

Two of our committee members attended courses at Johns Hopkins University in Baltimore, at which time they were instructed as to the necessary steps for setting up a medical program and the possible effects of an atomic bombing of an average American city. We anticipate that these two physicians, namely, Drs. Irwin M. Pochapin and Theodore P. Eberhard, will direct a professional and lay education program throughout the State in cooperation with the Governor's Committee on Civil Defense. A committee of three, including Drs. Eberhard, Pochapin, and Charles Wm. Smith, is presently studying such a program.

At the request of the Governor's committee, we have divided the State into fifteen districts which will be known as Medical Defense Areas. A member of our committee will coordinate medical activity and medical education within these areas. District coordinators will have a committee consisting of the medical coordinator of each county Civil Defense Committee within his area. These areas are designated as found in Appendix A to this report.

Our committee has appointed a deputy to serve as medical counsel to Colonel Acker's technical staff. This deputy is Dr. Robert P. Dutlinger, of Harrisburg, who meets once each week with Colonel Acker's staff to discuss medical problems.

At the last meeting of the committee held in Philadelphia on June 10, 1950, we recommended to the Governor's committee that all citizens of the Commonwealth be urged through voluntary and educational means to undergo blood typing. The exact methods to be used in encouraging the public will be decided between now and the October meeting. At the present

time we are conducting correspondence with the National Security Resources Board in regard to the following problems: a national standard marking system for blood-typing and recommendations concerning types and quantity of medical supplies which will be needed in Pennsylvania. A further report on these two items will be submitted in a supplemental report to the House of Delegates.

The Governor's Civil Defense Committee requested that we make a complete survey of all available medical supplies throughout the State of Pennsylvania. To the best of our knowledge, we do not know of any definite medical supply depots other than Army and Navy depots which might be used in the event of an atomic disaster. These would probably be unavailable for civilian use. We do know that the American Red Cross has certain limited facilities throughout the State, but it is our conclusion that these supplies would not be sufficient in the event that even one bomb were dropped within the boundaries of the Commonwealth. We are, therefore, planning on the assumption that complete supplies would have to be purchased and we have concluded that we cannot depend upon any civilian agencies, such as hospitals, to furnish the great quantity of medical supplies and equipment which would be required.

We have inaugurated a publicity campaign through our own State Society's public relations committee on the steps being taken by this committee in cooperation with the Governor's Civil Defense Committee plan for emergency in the event of atomic disaster. We shall report to the Board of Trustees at its July 27 and 28 meetings and hope to bring to the House of Delegates in October a full and concrete plan for the care and treatment of the sick and injured in the event of atomic bombings.

We call attention to Appendix A and recommend that this committee be continued for another year because of the unsettled world-wide conditions which necessitate continued vigilance on the part of our organization.

Respectfully submitted,

FREDERIC B. DAVIES	IRWIN M. POCHAPIN
EDWARD L. BORTZ	EMERALD M. RALSTON
THEODORE P. EBERHARD	CHARLES W.M. SMITH
ALLEN J. HANNEN	DONALD W. GRESSLEY
THEODORE R. FETTER, <i>Chairman</i>	



Appendix A

Members of the Committee on Emergency Disaster Medical Service are assigned to specific areas and will be the coordinators of the medical program throughout the areas assigned.

In each area, certain counties are included. These are listed below:

<i>Area No. 1—Harrisburg</i>	<i>Area No. 2—Philadelphia</i>
Dauphin County	Delaware County
York County	Montgomery County
Adams County	Philadelphia County
Franklin County	
Cumberland County	<i>Area No. 3—Pittsburgh</i>
Perry County	Allegheny County

Area No. 4—Bethlehem

Northampton County
Lehigh County
Bucks County

Area No. 5—Butler

Butler County
Beaver County
Lawrence County
Mercer County
Armstrong County

Area No. 6—Erie

Erie County
Crawford County
Venango County
Warren County

Area No. 7—Wyoming

Monroe County
Carbon County
Columbia County
Luzerne County
Sullivan County
Bradford County
Wyoming County

Area No. 8—Greensburg

Westmoreland County
Somerset County
Cambria County
Indiana County

Area No. 9—Hollidaysburg

Blair County
Bedford County
Fulton County
Juniata County
Mifflin County
Huntingdon County
Centre County

Area No. 10—Reading

Berks County
Lebanon County
Schuylkill County

Area No. 11—Montoursville

Lycoming County
Montour County
Northumberland County
Snyder County
Union County
Clinton County
Cameron County
Potter County
Tioga County

Area No. 12—Punxsutawney

Jefferson County
Clarion County
Forest County
Elk County
McKean County
Clearfield County

Area No. 13—Lancaster

Lancaster County
Chester County

Area No. 14—Washington

Washington County
Greene County
Fayette County

Area No. 15—Blakely

Lackawanna County
Pike County
Wayne County
Susquehanna County

The members of the committee responsible for the various areas are as follows:

Harrisburg area (1)—Dr. Charles Wm. Smith
Philadelphia area (2)—Dr. Theodore P. Eberhard and Dr. Edward L. Bortz
Pittsburgh area (3)—Dr. Irwin M. Pochapin
Bethlehem area (4)—Dr. Clifford H. Trexler
Butler area (5)—Dr. Donald W. Gressley
Erie area (6)—Dr. Emerald M. Ralston
Wyoming area (7)—Dr. Albert R. Feinberg
Greensburg area (8)—Dr. John J. Huebner, Jr.
Hollidaysburg area (9)—Dr. Harry W. Weest
Reading area (10)—Dr. Leroy A. Gehris
Montoursville area (11)—Dr. Joseph M. Korengo
Punxsutawney area (12)—Dr. Lamar M. Davenport
Lancaster area (13)—Dr. Charles S. Duttonhofer
Washington area (14)—Dr. Bruce R. Austin
Blakely area (15)—Dr. Frederic B. Davies

COMMISSION ON DIABETES

To the President and House of Delegates:

Your commission reports considerable effort in bringing the subject of diabetes before the general practitioner, who is primarily interested. The commission has again volunteered to furnish speakers to any county medical society on request. Also, the commission will furnish seminar programs on request by the county societies, under proper circumstances.

The commission has had two meetings since our last report—the first, on Sept. 28, 1949, in Pittsburgh; the second, at the University of Pennsylvania Hospital, Philadelphia, Jan. 29, 1950.

It was decided at these meetings that the commission should have a scientific exhibit at the 1950 State Society meeting. It was further decided that the caption for the exhibit should be "The Treatment of the Complications of Diabetes," and that all material prepared should be made to appeal to the general practitioner. To further the plans for such an exhibit, Dr. W. Wallace Dyer, of Philadelphia, was appointed general chairman of the booth committee. Dr. Dyer was requested to plan and furnish the display on eye complications of diabetes; Dr. J. West Mitchell, of Pittsburgh, a display on arteriosclerosis and heart complications in diabetes; Dr. Thaddeus S. Danowski, of Pittsburgh, a display on kidney complications and the general pathology in diabetes; Dr. Garfield G. Duncan, of Philadelphia, a display on diabetic coma. All of these tasks are well in hand at this writing.

The commission's painting "Diabetes, Then and Now" will again be exhibited at the commission's booth.

It was decided that the diabetes "pocketbook name cards" be revised, and that a printing of these cards be authorized by the commission.

The various members of the commission are taking an active part in the 1950 Diabetes Detection Drive, which is to take place during the week of Nov. 12-18, 1950.

The commission thanks the Board of Trustees and Councilors for its support and liberality in furnishing funds to carry on its work, and again extends thanks to Dr. Walter F. Donaldson, secretary and treasurer of the State Society, for his helpful suggestions, advice, and cheerful cooperation.

The commission also extends thanks to Mr. Robert L. Richards for his advice, secretarial work, and for sending out necessary communications to the members of the commission and to the county medical societies. Whatever success the commission has had is largely due to the work of Mr. Richards, and it is deeply appreciated by the commission.

Respectfully submitted,

LOUIS E. AUDET	ANGELO L. LUCHI
JOSEPH T. BEARDWOOD, JR.	FRANCIS D. LUKENS
S. MEIGS BEYER	J. WEST MITCHELL
W. WALLACE DYER	CAMPBELL MOSES
CLARENCE C. CAMPMAN	PAUL F. POLENTZ
THADDEUS S. DANOWSKI	CHARLES R. REINERS
GARFIELD G. DUNCAN	HARRY B. THOMAS
L. DALE JOHNSON	

GEORGE F. STONEY, *Chairman*

COMMISSION ON GRADUATE EDUCATION

To the President and House of Delegates:

The commission held one meeting during the interim on Oct. 28, 1949. Since that meeting, the 1949-1950 program has been completed and it is a matter of record that 845 physicians registered for the course. This was the final year of our three-year program and the commission, although not entirely satisfied, was generally pleased with the final outcome.

In order to furnish continued education at the post-graduate level and still maintain its original objective of training the general practitioner, the commission has arranged the following program for the 1950-1951 Graduate Education Institute:

Ten centers will be established throughout the State as teaching units. In each of the ten centers, lectures will be presented one day each week for five weeks in the fall and one day each week for five weeks in the spring. Twenty subjects have been selected for special attention and a total of 15 hours of intensified work will be given for each subject. The fee (\$25) will remain the same as in previous years, with the exception that any physician desiring to register for any single spring or fall course may register for a fee of \$15. The subjects which will be emphasized are: allergy, bones and joints, cardiology, dermatology, endocrinology, gastroenterology, genito-urinary diseases, gynecology, hematology, immunology, infectious diseases, metabolic diseases, neurology, obstetrics, parasitic diseases, peripheral vascular diseases, physical medicine and rehabilitation, psychiatry, pulmonary diseases, and special senses.

A brochure has been published for this program, and at the time of this writing approximately 100 physicians have registered for the course. We anticipate that registrations will not be as high this year as in previous years because of the specialized teaching program. However, the commission is of the opinion that the three-year course, having been designed to bring the general practitioner up to date, has fulfilled the need in that regard. It is therefore essential that the commission expand its activities into certain fields which will give special training to those who are interested. The Board of Trustees and Councilors has approved our new plan, and has granted us permission to complete the first year.

In order to recognize those physicians who assumed the Graduate Education Institute program for the first three-year period, and who have also attended at least 70 per cent of the sessions, the commission has received permission from the Board of Trustees to present Certificates of Attendance during the 1950 convention on Tuesday evening following the President's inauguration. With the certificates will be presented a gift copy of the article entitled "The Care of the Patient" by Francis W. Peabody, M.D. The commission believes that this article embodies the fine principles inherent in the practice of medicine. A special speaker will be present during the evening set aside for the President's inauguration, and it is hoped that this will add much to the occasion and will encourage other physicians to continue postgraduate study.

With the approval of the Board of Trustees, the commission established a special course in electro-

cardiography which was conducted in Harrisburg during the fall of 1949 and during the spring of 1950. Sixty-two physicians attended and completed the fall course, and 59 registered for the spring course. This is a self-sustaining program, and we expect to have it presented in the spring of each year until such time as the demand is satisfied.

In addition to the Graduate Education Institute and the electrocardiography course, the commission has cooperated with county medical societies in providing speakers for seminars and county medical society scientific meetings, and also cooperated with the Associated State Postgraduate Committee, which is an organization composed of the chairmen of the committees on postgraduate education of state medical societies. Our chairman has been honored by election to the position of secretary-treasurer of that organization.

We wish to take this opportunity to express our appreciation to the House of Delegates for the funds in excess of those provided by the subscribers' fees which have been provided by the Society during the past three years for the conduct of the Graduate Education Institute; to the faculty members of the medical schools within the State of Pennsylvania for their cooperation in providing teachers for our programs; to the directors of the centers; also to the county medical societies which have sponsored our teaching centers.

We recommend that this commission be continued for the next year.

Respectfully submitted,

WILLIAM BATES
CHARLES L. BROWN
ROBIN C. BUERKI
ROSS K. CHILDRIHOSE

SAMUEL P. HARBISON
WILLIAM S. McELROY
WARREN C. PHILLIPS

CHARLES W.M. SMITH, *Chairman*



COMMISSION ON INDUSTRIAL HEALTH AND HYGIENE

To the President and House of Delegates:

In our last report to the Board of Trustees and Councilors, we called attention to our current pamphlet, then in press, to be distributed to the industrial health committees of the component county medical societies. The pamphlet, entitled "Industrial Health Program," was soon ready for distribution and has had wide acceptance throughout the State and by the American Medical Association.

On Feb. 5, 1950, the commission met in Harrisburg for the primary purpose of reviewing certain chapters of an American Public Health Association survey entitled "Keystones of Public Health for Pennsylvania," also for other business. The ground work for these considerations had been laid at a meeting on Jan. 8, 1950, attended by Chairman Long, representing this commission. After due consideration of each individual recommendation in Chapters T, U, and V, the commission summarized its reaction as follows:

"It is apparent in this public health survey that most of the reforms do not need action of the Legislature. *Most of the recommendations we have endorsed can be made effective by the signatures of the proper authorities in the State Department of Health.* We recog-

nize that these signatures are the only things now needed to put the reforms recommended into effect, and *urge that they be forthcoming on such executive orders.*"

It is apparent from our conclusions at this meeting that the Commission on Industrial Health and Hygiene differs radically from the Commission on Preventive Medicine and Public Health, since we feel that accident prevention functions should remain in the State Department of Labor and Industry where they now are, *provided sufficient qualified personnel and funds are made available for that work.*

This meeting on February 5 marked the tenth anniversary of the beginning of interest on the part of The Medical Society of the State of Pennsylvania in industrial health through a separate committee or commission. It was decided that future activities of the commission should be concerned with the following lines of endeavor:

1. Study alcoholism in industry.
2. Attempt to correct the illegal status of nurses and first-aid men in industry who are practicing nursing without a physician behind them.
3. Cooperate in furthering total industrial health programs with management, labor, and the industrial physician working together.

In furtherance of these objectives, Dr. Harley and his group in Williamsport have already laid the groundwork for a study of alcoholism in industry, and there have been subsequent meetings to discuss this subject in various parts of the State.

Both the Pennsylvania State Nurses' Association and the Pennsylvania group of the National Organization for Public Health Nursing are working in conjunction with the medical profession to find the proper solution to the problem of the nurse and first-aid man in industry without a physician to back up their work. Nothing concrete has as yet been attained, but effort is progressing along that line.

The markedly increased numbers of labor union members now gradually being covered by contracts setting up health service for them merely points out the foresight of the Committee on Medical Economics and the Commission on Industrial Health and Hygiene of this society in their joint meetings and conclusions several years ago. Chairman Long has had literature sent to members of the commission, concerning the work of the Health Insurance Plan of Greater New York, which is twenty-four hour prepaid service on the basis of voluntary employer-employee contributions, such as is being adopted more and more frequently throughout the country.

The tenth annual Congress on Industrial Health was attended by Chairman Long as a representative of The Medical Society of the State of Pennsylvania, and the proceedings were reported by him to the President and Board of Trustees and Councilors. Dr. Everts, who also attended the Congress, kindly helped in the preparation of this report.

At the request of the Council on Industrial Health of the American Medical Association, lists of physicians who have industrial relationships in the three major

industrial areas of this state were sent to them for their future reference.

In the eastern part of Pennsylvania, in southern New Jersey, and in Delaware a new organization of industrial physicians and industrial hygienists has come into being, helped along by the efforts of Dr. Everts and the chairman of this commission. It is called the Philadelphia Interstate Association of Industrial Medicine and is now a recognized affiliate of the American Association of Industrial Physicians and Surgeons. The organizing committee included Dr. Everts as a member and Dr. Long as chairman. Both are members of the board of directors of the new organization, and Dr. Long has been named district councilor of the American Association of Industrial Physicians for Delaware, southern New Jersey, and southeastern Pennsylvania.

Dr. Herman A. Fischer represented the commission, and through it our society, when the 1949 Pennsylvania Ambassador Award was made to Gladys Noss Dundore, R.N., at Hazleton on Oct. 21, 1949. Dr. Fischer, through his Luzerne County nursing affiliations, was instrumental in founding an Industrial Nurses' Section in the Pennsylvania State Nurses' Association. The first meeting of this new section was held in Wilkes-Barre on June 3, 1950, at which your chairman talked on "The Future of Industrial Nursing."

Finally, a note on the status of the teaching of industrial medicine in graduate and undergraduate medical schools in Pennsylvania. After long years of service, Dr. T. Lyle Hazlett, one of our commission members, retired from the professorship of industrial medicine at the University of Pittsburgh. He has been renowned for the excellence of his courses, both at undergraduate and graduate levels, and the university will sorely miss his pioneering spirit. In the five Philadelphia medical schools no change can be reported for the past year, but it is hoped that a Committee on Medical Education in the new Philadelphia Interstate Association of Industrial Medicine may stimulate some changes for the better in these medical schools.

The commission looks forward to next year as one of increased activity along the three lines noted above, with special emphasis on establishing proper relationships between the component county Committees on Industrial Health and the myriad new plans instituted by labor and management for the maintenance of twenty-four hour health service for those who work, and often for their dependents.

Respectfully submitted,

T. LYLE HAZLETT	CHARLES A. LEHMAN, SR.
DONALD J. MCCORMICK	GLENN S. EVERTS
HERMAN A. FISCHER, JR.	FRED J. KELLAM
EARL F. HENDERSON	JACK C. REED
DAVID N. INGRAM	WILLIAM B. WEST
CHARLES-FRANCIS LONG, <i>Chairman</i>	
JOHN P. HARLEY, <i>Co-chairman</i>	
DANIEL C. BRAUN, <i>Co-chairman</i>	

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**STATE HEALING ARTS ADVISORY
COMMITTEE**

To the President and House of Delegates:

A meeting of the State Healing Arts Advisory Committee was held June 14 in the conference room of the

Department of Public Assistance in Harrisburg. Irregularities in doctors' invoices, most of which concerned more than three calls in chronic cases, were discussed.

The question of limiting the service to three calls in chronic cases is one of considerable variability. Department representatives were again informed by your representative that this was a matter for individual consideration. The methods of treating anemia and edema due to cardiovascular-renal disease and a number of other conditions have changed considerably as a result of medical research. In anemia, injections of iron or liver preparations are used which should be administered as often as three times a week. In general edema, salts of mercury and arsenic are administered hypodermically as often as three times a week. In asthmatic conditions and in some other chronic conditions, acute exacerbations occur which require more than three calls a month.

The Department representatives have been very cooperative and are doing the best they can with the deficit appropriation. They were rather insistent, however, that the participating physicians in the program make only three calls a month on all cases whether acute or chronic.

This is the usual result of a tax-supported program. The cost of the program rises as a result of improvements of service, but appropriated funds remain the same. Those administering the program are always attempting to curtail cost by placing the burden on those rendering the service or providing the commodity. This is just what is taking place at the present time in the medical care program in the Department of Public Assistance.

Under present economic conditions, in some communities, a large number of individuals are on the relief rolls. Here it would be too much of a burden for physicians participating in the program to provide services and remedies at their own expense over and above the three calls permitted on each case.

As new remedies and new methods of procedure and diagnosis come into existence, the cost of the program is bound to rise. If tax funds are not available, then some other means through voluntary measures must be provided.

The Legislature is reluctant to levy more taxes and appropriate more funds for relief. Until the general public is informed and willing to assume the tax burden, this whole question is going to develop into a very controversial one.

NUMBER OF PHYSICIANS PARTICIPATING IN MEDICAL
PROGRAM
January, 1949 to December, 1949

Month	Number	Month	Number
1949			
January	3019	July	3258
February	3011	August	3319
March	3240	September	3343
April	3220	October	3430
May	3230	November	3528
June	3234	December	3578

MEDICAL EXPENDITURES BY TYPE OF PRACTITIONER
January, 1949 to December, 1949

Month	Total	Physicians	Clinics	Dentists	Nurses	Pharmacists
1949						
January	\$327,507	\$159,825	\$17,690	\$41,323	\$10,799	\$97,870
February	340,623	169,866	17,631	43,286	10,514	99,326
March	393,596	182,446	21,318	54,981	11,801	123,050
April	381,673	177,375	21,458	54,172	11,417	117,251
May	390,744	175,937	21,565	65,635	11,651	115,956
June	375,096	166,180	22,300	56,074	11,958	118,584
July	360,183	156,944	20,217	55,403	11,262	116,357
August	408,678	180,060	22,014	61,500	12,033	133,071
September	408,036	180,647	22,024	59,286	10,949	135,130
October	456,112	196,849	23,902	66,660	12,741	155,960
November*	446,000	193,000	24,000	62,000	13,000	154,000
December*	466,000	202,000	21,000	67,000	14,000	162,000

* Partially estimated

Mr. Wray, deputy secretary of the Department of Public Assistance, again presented his program. He suggested that the Department endeavor to find out the average cost of the medical care program in each county, and then request each participating doctor to accept the amount of his average invoices and treat the patients.

Under this program, when there is considerable sickness, a doctor would render more service than he would receive a fee for. In other words, it is simply a form of contract practice.

The Department representatives were informed by the members of the State Healing Arts Advisory Committee that they did not believe their respective organizations would accept a program of that kind, nor one in which only three calls a month were allowed. It was suggested, however, that if a county medical society wanted to experiment with a program of that kind, the

Department could give it a written explanation of the program, which the county society could present to its Committee on Medical Economics and then to the State Medical Society Committee on Medical Economics for its approval.

There will be another meeting of the State Healing Arts Advisory Committee in September, at which time these questions will again be discussed. It may be necessary for the House of Delegates to take some official action on the proposals of the Department representatives regarding the increase in the cost of the program.

Tabulations indicating expenditures and the number of physicians serving under the medical assistance program which have been received from the Department of Public Assistance are appended to this report.

Respectfully submitted

C. L. PALMER, *Chairman*

PER CENT DISTRIBUTION OF MEDICAL EXPENDITURES BY TYPE OF PRACTITIONER
January, 1949 to December, 1949

Month	Total	Physicians	Clinics	Dentists	Nurses	Pharmacists
1949						
January	100.0%	48.8%	5.4%	12.6%	3.3%	29.9%
February	100.0	49.9	5.2	12.7	3.1	29.1
March	100.0	46.3	5.4	14.0	3.0	31.3
April	100.0	46.5	5.6	14.2	3.0	30.7
May	100.0	45.0	5.5	16.8	3.0	29.7
June	100.0	44.3	5.9	15.0	3.2	31.6
July	100.0	43.6	5.6	15.4	3.1	32.3
August	100.0	44.1	5.4	15.0	2.9	32.6
September	100.0	44.3	5.4	14.5	2.7	33.1
October	100.0	43.2	5.2	14.6	2.8	34.2
November	100.0	43.2	5.4	13.8	3.0	34.6
December	100.0	43.3	4.6	14.4	3.0	34.7

COMMISSION ON MATERNAL WELFARE

To the President and House of Delegates:

The work of our commission has been somewhat handicapped due to the fact that the Bureau of Vital Statistics of the State Department of Health was unable to furnish photostatic copies of maternal death certificates at any time during the year 1949. This occurred because a new system of filing, coding and indexing deaths was being inaugurated in the Department of Health. No death certificates were received for 1949 until the middle of February, 1950, and at the present time the commission has received reports of maternal deaths only up through July, 1949. Because of this unavoidable situation it has been unable to allocate the death certificates to the county society chairmen for their study, but it is believed that since the system has now been set up we can soon begin to send out forms and material to the various county chairmen.

Eliminating from study of the first seven months of 1949 the cases of abortion and ectopic pregnancy and truly non-obstetric deaths, the following summary for seven months of 1949 is herewith presented:

Deaths	
Obstetric shock	3
Pulmonary embolus	6
Inversion of uterus	1
Acute heart failure	3
Sepsis	2
Ruptured uterus	5 (1 after previous section, 1 after criminal abortion, 3 spontaneous)
Abdominal pregnancy ..	2
Anesthetic deaths	3 (1 sodium pentothal and nitrous oxide, 2 from spinal)
Eclampsia	12 (1 with abruptio placentae, 3 associated with cesarean section)
Obstetric hemorrhage	
Placenta previa	4 (1 with postpartum hemorrhage, 1 associated with section)
Abruptio placentae ...	5 (1 associated with Porro section)
Postpartum hemorrhage	8 (1 following placenta previa)
Cesarean section	8 (1 for placenta previa, 1 Porro for abruptio placentae, 1 in diabetes, 1 in eclampsia and shock, 1 with peritonitis, 1 with the right ureter tied in a low cervical section, 2 from operation itself other than the one above with the tied ureter)

The figures showing 8 cesarean deaths, 8 postpartum hemorrhages, 4 of ruptured uteri, and the 3 anesthetic deaths, as well as 3 maternal deaths from obstetric shock, clearly show that much is yet to be done in overcoming and eliminating a considerable number of these maternal deaths.

The final maternal death rate for 1949 is unavailable at this time, but it is believed that it will be comparable to that of 1948, which was slightly over 1 per 1000 live births.

In January the chairman of the commission participated in a meeting in Harrisburg, at which time a study was made of the "Keystones of Public Health for Pennsylvania," which was the result of the survey of health in Pennsylvania by the American Public Health Association. In this report the maternal welfare and the puerperal death rate in Pennsylvania were most thoroughly surveyed. Quoting from a digest of this survey, the following data are given regarding Pennsylvania: "If the State with the best record is rated first, Pennsylvania's puerperal death rate in 1945 was 31st, New York's 22nd, and New Jersey's 14th."

Since 1945 there has not been an appreciable decline in the maternal death rate and, if a survey was made at the present time, it is believed that Pennsylvania's standing among the states would be the same as in 1945.

As in previous reports, your commission has alerted the profession to the apparently unnecessary or preventable maternal deaths from obstetric hemorrhage, especially postpartum, from cesarean section deaths, from ruptured uteri, and from eclampsia; in the first seven months of 1949 there were three purely anesthetic deaths, two of which were from spinal anesthesia.

The work done by the hospital staffs throughout the State in reviewing maternal deaths has alerted that part of the profession, but the general practitioner in many instances has not been included. The long and short special forms for the survey of maternal deaths will be sent out to each physician who was involved in any maternal death, and it is sincerely hoped that the photostatic copies from the Bureau of Vital Statistics of the reports of such deaths will continue to be received so that this important work will not fall by the wayside.

It is hoped that the House of Delegates will see fit to continue this commission, for it is believed that there is still much work to be done in further reducing the maternal death rate in Pennsylvania.

Respectfully submitted,

CLAYTON T. BEECHAM	HERBERT A. MARRACH
JOSEPH H. CARROLL	ROY E. NICODEMUS
RAYMEN G. EMERY	JOHN B. NUTT
JOSEPH J. KOCYAN	FREDERICK J. PEARSON
WALTER J. LARKIN	HOWARD A. POWER
	JAMES S. TAYLOR, <i>Chairman</i>

COMMISSION ON LABORATORIES

To the President and House of Delegates:

The commission has no formal annual report. Its activities have been in abeyance while efforts were being made to have other organizations, such as the Hospital Association of Pennsylvania, accept the results and recommendations made by it in previous years.

The commission expects in the coming year to make additional recommendations to The Medical Society of the State of Pennsylvania extending still further the improvement in laboratory practices.

Respectfully submitted,

GEORGE H. FETTERMAN	GEORGE R. LACY
JAMES S. FORRESTER	FRANK B. LYNCH
ELWYN L. HELLER	THOMAS W. McCREARY
HENRY F. HUNT	

WILLIAM P. BELK, *Chairman*

COMMISSION ON MENTAL HYGIENE

To the President and House of Delegates:

The year 1950 has presented no serious problems to the commission. One meeting was held on Jan. 15, 1950. Its minutes have already been reported to the Board of Trustees and Councilors and action on its recommendations is a continuing process, which will require considerable time and the assistance of other commissions.

We believe that the objectives adopted by our commission for 1950 merit their being placed before the membership of the entire state society, since they embrace factors which are of interest to all physicians and to many of their patients.

Objectives for 1950

1. A. We note that some mental hospitals have increased their capacity and that admissions to some are being expedited.
- B. We also note that the building program in other mental hospitals will within the year probably do much to eliminate the jail as a way station. The commission notes that this condition does not exist in all hospitals.
- C. We reiterate the recommendation made in 1949 that the Department of Welfare use all means possible to provide for the prompt admission of urgent mentally ill cases in mental hospitals and to eliminate insofar as possible the jail as a way station for the admission of mentally ill patients to hospitals.
2. A. We re-emphasize to the county societies the importance of promoting facilities in general hospitals for the temporary care of acute mental disturbances under qualified supervision, and we again urge the county societies to publicize their local needs in this matter to the end that all general hospitals will be prepared to fulfill their duties to the community as general hospitals. We further urge that the Department of Welfare advise the communities of the additional maintenance offered community hospitals who fulfill their obligations in the care of acute mental cases.
- B. The commission recognizes that at the present time delay in the admission to state hospitals of acutely psychotic cases sometimes interferes with the smooth functioning in the care of psychotic patients in general hospitals. It urges that local county societies do what they can to straighten out difficulties where they arise. The commission feels that the state hospital system might

well give preference to community hospitals caring for acutely disturbed patients.

3. We again urge that each county society have as one of its standing committees a Committee on Mental Hygiene, whose duty it shall be to increase public interest in the problems of mental hygiene, with particular support of the mental hospitals in their districts. We further urge that the county societies disseminate information regarding mental hygiene to the public in their communities; and we urge that they emulate the fine examples set by the Philadelphia and Allegheny County Societies in this regard.
4. We continue to urge that the State Board of Medical Education and Licensure recognize the importance of psychiatric training during internship and urge that superintendents of state mental hospitals qualify their hospitals for approved intern training.
5. The commission again recommends that legislation which would permit mental hygiene clinics in Pennsylvania to receive a share of Federal aid monies now earmarked for such clinics be supported, and the commission urges the acceptance by the State of funds available for mental hygiene purposes.
6. The commission notes that much of the overcrowding now present in state mental hospitals is attributable to the relative increase in aged patients chiefly requiring infirmary type care and *not* in need of active psychiatric treatment. The commission believes and recommends that the use of *county infirmaries* for the care of such patients offers a solution to part of the overcrowding problem. It further recommends that legislation which would further this type of care be urged upon the authorities of the various counties and upon the Welfare Department.
7. The commission urges that careful study be given to the enactment of legislation which would provide for the segregation, care, and treatment of sex offenders, and that any legislation drafted for the care of sex offenders be carefully scrutinized to avoid the defects noted in the bill introduced in the last session of the Legislature.

At the request of the Commission on Preventive Medicine and Public Health, the commission reviewed and reported upon that portion of the American Public Health Association survey report referable to mental health. These recommendations are in line with the commission's previously expressed attitude on mental hygiene as a function of the State Health Department and are incorporated in the minutes of our meeting.

Various members of the commission have taken part in mental hygiene programs in component county societies and the commission membership is available for advice on topics pertaining to mental health.

We recommend the continuance of this commission for another year.

Respectfully submitted,

JOSEPH A. CAMMARATA	ROBERT A. MATTHEWS
JOHN N. FREDERICK	ARTHUR P. NOYES
SAMUEL B. HADDEN	J. FRANKLIN ROBINSON
JAMES M. HENNINGER	JACK D. UTLEY
PETER O. KWITEROVICH	

HAMBLETON C. EATON, *Chairman*

COMMISSION ON NUTRITION

To the President and House of Delegates:

The commission was reactivated in January, 1950, under the chairmanship of Dr. Michael G. Wohl, of Philadelphia. The first task of the commission was to review "Keystones of Public Health for Pennsylvania," a public health survey of the State of Pennsylvania, with particular reference to the recommendations in the field of nutrition.

A formal report was submitted to the chairman of the Commission on Preventive Medicine and Public Health. The commission endorsed the findings of the American Public Health Association and, in addition, laid particular emphasis on the recommendation that physicians play a larger role in the over-all planning of the nutritional program of the State of Pennsylvania in research, clinical, and educational aspects.

The second task undertaken by the commission was the organization and preparation of a series of editorials on various phases of nutrition in relation to clinical medicine for publication in the PENNSYLVANIA MEDICAL JOURNAL. A total of twelve editorials was planned. Of these, four have been published so far, and by the time this report is printed, a fifth editorial will have appeared in the JOURNAL.

The following topics were covered in the editorials: *Vitamin Antagonists—Clinical Implication, Nutrition and Anemia, Childhood Feeding, Protein in Nutrition, and Undernutrition.*

The commission believes that this program of education should prove of considerable value to the members of the State Medical Society by bringing to them the newer developments in the field of nutrition as applied to clinical problems.

Respectfully submitted,

HORACE B. ANDERSON	HARVEY H. SEIPLE
WILLIAM J. ARMSTRONG	RALPH L. SHANNO
LUTHER I. FISHER	PAUL C. SHOEMAKER
PAUL G. SHALLENBERGER	JAMES M. STRANG
JOHN M. HIGGINS	JOHN B. TREDWAY
THOMAS E. MACHELLA	JOHN J. WALSH

MICHAEL G. WOHL, *Chairman*



COMMISSION ON PHYSICAL MEDICINE AND REHABILITATION

To the President and House of Delegates:

The commission has held four meetings since the last meeting of the House of Delegates and contemplates holding a fifth meeting prior to October, 1950.

During the 1949 meeting of the House of Delegates, a resolution was introduced and approved which directed our commission to conduct a survey of rehabilitation facilities in the State of Pennsylvania. This has been our chief concern and we wish to report considerable progress in this respect.

We have presented several progress reports to the Board of Trustees and Councilors, which has encouraged our commission to attempt to conduct this survey without expenditure of a great amount of funds. The commission has attempted to do so through the distribution of survey questionnaires to all hospitals in Pennsylvania.

A final copy of the survey statistics will probably be presented directly to the House of Delegates. However, we can at this time report that the survey of Philadelphia, Montgomery, and Delaware counties has been almost completed through the cooperation of the Health and Welfare Council, Inc., Philadelphia. The survey of the other 64 counties has been conducted through the facilities of the Hospital Association of Pennsylvania and questionnaires are being tabulated at the present time.

At the request of the Commission on Preventive Medicine and Public Health, our commission reviewed Chapter R (Crippled Children's Program) of the survey report entitled "Keystones of Public Health for Pennsylvania." A final report of our recommendations on this chapter has been submitted to that commission and will, in turn, be presented to the Board of Trustees within the next few months.

This commission, previously known as the Commission on Physical Medicine, recommended to the Board of Trustees that its name be changed to the Commission on Physical Medicine and Rehabilitation. Inasmuch as the Board of Trustees of the American Medical Association changed the name of its Council on Physical Medicine to Council on Physical Medicine and Rehabilitation, our Board of Trustees agreed that the name of our commission should be identical. Therefore, the Board of Trustees approved our request.

During the past year this commission has cooperated with the Commission on Graduate Education in arranging a course on physical medicine and rehabilitation for their 1950-51 course, and we are grateful for this opportunity. We hope that the program will be well received by the general practitioners throughout the State.

We are now planning a scientific exhibit for the 1950 State Society convention, which will be presented in cooperation with other agencies throughout the State which interest themselves in physical medicine and rehabilitation services. This exhibit is to demonstrate the care and treatment of the patient from the time he enters the hospital until such time as he has been rehabilitated and has returned to his former employment or is employed in a sheltered workshop. We believe that this will be one of the most outstanding exhibits ever presented during a convention of The Medical Society of the State of Pennsylvania.

We recommend that this commission be continued for another year.

Respectfully submitted,

TEMPLE FAY	WILLIAM H. SCHMIDT
GEORGE M. PIERSOL	JESSIE WRIGHT
WILTON H. ROBINSON	NICHOLAS D. MAURIELLO
ULRICH D. RUMBAUGH	HERMAN RUDOLPH

ALBERT A. MARTUCCI, *Chairman*



COMMISSION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

To the President and House of Delegates:

Since our report to the 1949 House of Delegates, the commission has held four meetings. The first of these

was in conjunction with representatives of the staff of the School of Public Health in Pittsburgh, at which time Dr. Thomas Parran discussed the organization of the new school. This information was reported to the Board of Trustees and Councilors at a subsequent date.

Included in retiring President Engel's address to the 1949 House of Delegates was a recommendation which placed the responsibility for reviewing the survey report entitled "Keystones of Public Health for Pennsylvania" upon the Board of Trustees. The board in turn requested our commission to implement this study by referring for review and comment the various chapters of the survey report to appropriate commissions and committees of the State Society and, thereafter, correlating the reports as received.

At a meeting of commission chairmen on Jan. 8, 1950, this assignment of responsibilities was thoroughly discussed. The various chairmen were given to understand that a report should be submitted to us for correlation with other commission reports and subsequent submission to the Board of Trustees.

In the interim, the members of our commission reviewed each chapter of the survey report and prepared abstracts which eventually were published as editorials in the PENNSYLVANIA MEDICAL JOURNAL. Prior to publication, these editorials were submitted to the Secretary of Health, Dr. Norris W. Vaux, for his comments.

The commission also reviewed and prepared revisions of the communicable disease regulations and, with the approval of the Board of Trustees, submitted these suggested revisions directly to Dr. Norris W. Vaux, Secretary of Health, for discussion with his Advisory Health Board.

One of the principal activities of this commission during the past year has been to cooperate with other health agencies, lay and professional, in discussing the recommendations made in the survey report. Representatives of the State Health Department, the Pennsylvania Citizens Association, and the Pennsylvania Tuberculosis and Health Society were invited to a joint meeting on Jan. 8, 1950, at which time coordination of effort was discussed and some planning was outlined in regard to the implementation of the survey recommendations.

Three direct results of this meeting were: (1) implementation of the recommendations was assigned to the Pennsylvania State Health Council, which has accepted this responsibility; (2) a reprinting of the complete survey report in quantity, which is being performed through the offices of the Pennsylvania Citizens Association; and (3) publication of the *Digest* of the Digest entitled "Pennsylvania's Health Is Your Concern."

The commission has been responsible for the preparation of an exhibit which emphasizes the fact that the House of Delegates approved two *keystones* of the report, namely, revision of the system of employment and the establishment of local health units. This display was exhibited during the annual Secretaries and Editors Conference in Harrisburg on March 2 and 3, 1950, and has been displayed on several other occasions at meetings of lay and professional organizations. It will also be used as an exhibit during the annual meeting of the State Society in October. In addition, the

commission members have cooperated in speaking before lay and professional audiences on the survey recommendations. These are too numerous to list in this report, but they are recorded in the minutes of our meetings.

From time to time, the commission has submitted progress reports to the Board of Trustees and Councilors regarding the correlation of the commission's reports on the survey recommendations. At the May 12 meeting the Board of Trustees reaffirmed, after detailed study, the resolution submitted to the House of Delegates at its 1949 meeting which, in essence, approved survey recommendations Nos. 4 and 6. It also reviewed in detail several reports on chapters in the survey report, the results of which have not as yet been made public because the study is not completed at the present time.

It is hoped that a final report will be submitted to the Board of Trustees during its October meeting, at which time we hope to discuss with the board the further implementation of the recommendations which have been approved and those which may be approved at that time.

We wish to take this opportunity to express our appreciation to the Board of Trustees and other officers, chairmen of the various committees and commissions who have cooperated with us in the study of the survey report, and to the secretarial staff for their most valuable assistance.

We recommend that this commission be continued for the next year.

Respectfully submitted,

I. HOPE ALEXANDER	GEORGE S. KLUMP
J. MOORE CAMPBELL	WILLIAM S. McELROY
VINCENT T. CURTIN	WILLIAM H. PERKINS
GEORGE R. GOOD*	RUFUS S. REEVES
W. BENSON HARER	OLIVER E. TURNER
	PASCAL F. LUCCHESI, <i>Chairman</i>



ADVISORY COMMITTEE TO PENNSYLVANIA BOARD FOR VOCATIONAL EDUCATION

To the President and House of Delegates:

There have been no meetings of the advisory committee during the past year.

The Commission on Preventive Medicine and Public Health requested the Board of Trustees to make a survey of rehabilitation equipment in Pennsylvania institutions. Mr. Floyd L. Kefford, acting chief of physical restoration, State Board of Vocational Education, Bureau of Rehabilitation, indicates that there are no institutions in Pennsylvania which have both physical and vocational rehabilitation facilities. Pennsylvania sends its cases to the Woodrow Wilson Rehabilitation Center in Fishersville, Va., for complete treatment.

Respectfully submitted,

EARL D. BOND	T. LYLE HAZLETT
FREDERICK A. BOTHE	DOUGLAS MACFARLAN
JOSIAH F. BUZZARD	ALBERT A. MARTUCCI
ALLEN W. COWLEY	WILTON H. ROBINSON
	C. L. PALMER, <i>Chairman</i>

* Deceased July 21, 1950.

CONFERENCE OF PROFESSIONAL LICENSEES

To the President and House of Delegates:

There have been no meetings of the conference during the past year, but this organization will no doubt become more active as the legislative session approaches.

Respectfully submitted,

C. L. PALMER



COMMISSION TO STUDY CONTROL OF RHEUMATIC FEVER

To the President and House of Delegates:

Three stated meetings were held by the commission during the past year, in addition to several meetings of subcommittees and joint meetings of the commission with other groups.

The state-wide survey of rheumatic fever cases has been in operation for over a year. All practicing physicians are requested to report their cases. Hospitals and all institutions treating patients with rheumatic fever also are requested to participate. The data already acquired will soon be published in the JOURNAL. The commission now feels that, in addition to the advantages of accumulating data on the incidence of rheumatic fever, the survey is of value in alerting the practicing physician to the extent of the rheumatic fever problem. In the past, reports were confined to children; now, reports on patients of all ages are contemplated.

The commission has secured the appointment of a "rheumatic fever" chairman in each of the county societies. These chairmen have been asked to stimulate arrangements for holding yearly symposia on rheumatic fever or rheumatic heart disease as a part of each county society's scientific program. In addition, they are requested to assist lay groups in arranging programs. The cooperation of these chairmen has been excellent, with several counties inaugurating very useful programs.

The commission will present an exhibit at the October, 1950 State Society convention. Tentative plans are for a presentation of data on the use of sulfanilamide in the treatment of rheumatic fever. During the convention, a meeting of the 60 county chairmen will be held. Members of the commission are highly pleased with the establishment of a new integrating group which will consist of the commission itself, members of the Division of Rheumatic Fever Control of the State Health Department under Drs. Paul Dodds and Mary Richardson, and the Committee on Rheumatic Fever Control of the new Pennsylvania Heart Association. The chairman of the association's committee is Dr. James R. Kitchell, of Philadelphia, who is also a member of our commission. A joint meeting of these three bodies was held in May. It is obvious that the correlation of the activities of these groups can now be facilitated. In addition, each of the three can see its own problems in a clearer light. Now that the facilities of the Pennsylvania Heart Association (as for the distribution of pamphlets) are available, the work of the commission will be increasingly more effective.

The commission wishes to thank the many physicians throughout the State who are cooperating in reporting their rheumatic fever cases.

We recommend that this commission be continued for the next year.

Respectfully submitted,

ALLEN W. COWLEY

CONSTANTINE P. FALLER

FRANK J. GREGG

MARK P. HOLLAND

WILLIAM D. STROUD, *ex officio*

JAMES R. KITCHELL

PAUL B. KREITZ

JOHN M. MITCHELL

THOMAS P. TREDWAY

RALPH L. SHANNO, *Co-chairman*

ANDREW B. FULLER, *Chairman*



COMMISSION ON THE CONTROL OF SYPHILIS AND VENEREAL DISEASES

To the President and House of Delegates:

This commission participated actively with the Commission on Preventive Medicine and Public Health in the analysis and implementation of the essential portions of the report entitled "Keystones of Public Health for Pennsylvania." A detailed conference on public health and venereal disease control was held with the chief of the Venereal Disease Division, Pennsylvania Department of Health, the result of which was a written statement by the latter which will serve the purpose of additional study in drafting a cooperative program. The report of the commission's review of the state health program for venereal disease control and its recommendations are matters of record.

Distribution of the booklet, "The Control of Syphilis by Means of Penicillin," to the physicians throughout the State has resulted in wide favorable comment. In addition to the mail circularization, this pamphlet was distributed at the syphilis lectures as a part of the graduate education program of the State Society.

Members of the commission also assisted the State Department of Health in a symposium at Pittsburgh on Dec. 1, 1949. This stimulated the publication of a second booklet by the Department of Health, "Syphilis and Penicillin 1950," which adequately supplements and brings up to date the work of the commission in this field.

There is a need to accurately define the venereal disease problem in private medical practice throughout the State. The definition is reasonably accurate for public and private clinic facilities, but the many ramifications of case finding and case holding which affect private medical practice are less accurately studied and are essential to a knowledge of the over-all program.

The commission has received a letter from the State Department of Health appealing for assistance in this field. This will be one of the chief activities of the commission during the coming year.

The commission regrets the resignation of Dr. Samuel L. Grossman as its chairman during the course of the year because of serious illness.

Respectfully submitted,

PAUL M. CORMAN

ALBERT F. DOYLE

LEO P. GIBBONS

SAMUEL L. GROSSMAN

NORMAN R. INGRAHAM, Jr., *Acting Chairman*

ROBERT C. HIBBS

RAYMOND RICKLOFF

HAROLD R. VOGEL

JOHN F. WILSON

COMMISSION ON TUBERCULOSIS

To the President and House of Delegates:

The commission has held two meetings, the first at Devitt's Camp in Allenwood, Pa., which was combined with a meeting of the Pennsylvania Chapter of the American College of Chest Physicians.

The second meeting was held on Jan. 14, 1950, at which time the commission reviewed and approved the recommendations contained in Chapter K of the survey report entitled "Keystones of Public Health for Pennsylvania." Inasmuch as the survey report contained recommendations relative to the use of children's beds in the Preventorium of the Mt. Alto State Sanatorium, the commission unanimously agreed upon the following resolution:

That, if there is any conversion of children's beds in the Preventorium or any of the State sanatoria, it should be for the care of tuberculous patients rather than patients with other diseases.

It is appropriate to note at this time that there were approximately 700 to 800 individuals in the State suffering from tuberculosis who could not be admitted to the State sanatoria because of the lack of medical facilities. It was generally agreed that this waiting list was not caused by a lack of hospital facilities, but was due to a lack of medical personnel such as physicians, nurses, technicians, etc. This lack of personnel stems from the inadequacy of the pay schedule as presently followed by the Bureau of Tuberculosis Control. The commission hopes that this situation may be remedied in the near future and has expressed confidence in the State Health Department in this respect.

The commission invited Dr. Morrison C. Stayer, director of the Bureau of Tuberculosis Control of the Pennsylvania Health Department, to be present at the second meeting. Dr. Stayer reviewed the present program of the Bureau of Tuberculosis and outlined his plans for the future. Following detailed discussion of Dr. Stayer's comments, the following resolution was unanimously adopted:

That the Commission on Tuberculosis of The Medical Society of the State of Pennsylvania commend Dr. Stayer for his efforts made to date in the program of the Bureau of Tuberculosis Control and that the commission concurs in general with his objectives as outlined at the Jan. 14, 1950 meeting of the commission.

A copy of this resolution was forwarded to Dr. Norris W. Vaux, State Secretary of Health, and also to the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania.

We recommend that this commission be continued for another year.

Respectfully submitted,

RUSSELL S. ANDERSON	ELMER HIGHBERGER, JR.
JOHN H. BISBING	VICTOR M. LEFFINGWELL
KATHARINE R. BOUCOT	ROYAL H. MCCUTCHEON
HAROLD T. BROWN	CHARLES H. MINER
W. EDWARD CHAMBERLAIN	JOHN S. PACKARD
DAVID A. COOPER	MARTIN J. SOKOLOFF
ESTEN L. HAZLETT	DALE C. STAHL
CHARLES A. HEIKEN	MICHELE VIGLIONE
ROSS K. CHILDHEROSE, <i>Chairman</i>	

Where to Meet Your Friends in Philadelphia

RELIGIOUS HOUR—4:00 p.m., Sunday,
October 15

Irvine Auditorium, University of
Pennsylvania Campus

Speakers—Dr. Bertram W. Korn, Senior Rabbi, Temple Kenceth Israel, Philadelphia; the Rev. Linn Bowman, Chaplain, Eastern Penitentiary, Philadelphia; and Dr. W. Hamilton Aulenback, Rector, Christ Church and St. Michael's (Episcopal), Germantown, Philadelphia. Music by the Men's Glee Club, University of Pennsylvania; Robert S. Goddall, director.

BUFFET SUPPER—5:30 p.m., Sunday, Oc-
tober 15

Houston Hall, University of Pennsylvania
Campus

Subscription—\$2.00

THIRD ANNUAL STATE DINNER—7:00
p.m., Monday, October 16

Ballroom, Bellevue-Stratford Hotel
Subscription—\$5.00

◆
INSTALLATION MEETING—8:00 p.m.,
Tuesday, October 17

Ballroom, Bellevue-Stratford Hotel
Installation of Harold B. Gardner as 101st
president of The Medical Society of the State
of Pennsylvania.

◆
PRESIDENT'S RECEPTION—9:00 p.m.,
Wednesday, October 18

Ballroom, Bellevue-Stratford Hotel
Dancing to one of Philadelphia's best orchestras.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade, Pittsburgh 22

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

FORMAL OPINION AFFECTS ALL PHYSICIANS IN PENNSYLVANIA

On the request of the Honorable Norris W. Vaux, State Secretary of Health, Harrisburg, the State Department of Justice has released an opinion, concerning which current news statements indicate that physicians will no longer be privileged to order hypnotic, analgesic, and bodyweight reduction drugs over the telephone nor have their prescriptions signed by an assistant.

This opinion concerns the interpretation of Act 407 of the 1935 Session of the Pennsylvania Legislature—the Dangerous Drug Act. At that time a number of automobile accidents and other serious incidents were reported to the Narcotic Division of the Department of Health for which narcotic addicts were held responsible, and their addiction was attributed to the indiscriminate use of barbiturates and other hypnotic drugs dispensed over the counters of drug stores without prescriptions.

This led to drafting Act 407. At that time The Medical Society of the State of Pennsylvania, in the interest of public health and prevention of addiction, approved this act.

Since then, according to the Narcotic Division of the Department of Health, considerable laxity has developed in the interpretation of the act which has resulted in many people obtaining large quantities of these drugs and becoming addicts.

This prompted Secretary Vaux to ask for a legal opinion regarding the provisions of this act.

The opinion is known as *Formal Opinion No. 614* and was released July 3, 1950. The request was for an interpretation of Section 2 of this act, which section is worded as follows:

* "It is clearly the intent of Act 407, P.L. 1935, to regulate the dispensing of barhital and other hypnotic drugs in such a manner as to prevent their harmful effects. The medical profession appears to be convinced that these drugs have a tendency to become habit-forming and that their continued use results in an addiction which is difficult to overcome. Acute and chronic intoxication frequently results from the lay use of the drugs incorporated in the Act" (page 22, Rules and Regulations of the Division of Narcotic Control, Department of Health).

"No hypnotic drug or analgesic or bodyweight reduction drug, as defined herein, shall be sold at retail or dispensed to any person except upon the written prescription of a duly licensed physician, dentist, or veterinarian. . . ."

Following the opinion, Secretary Vaux makes the following inquiries regarding the above provision:

1. May such prescriptions be written and signed by a physician's secretary or other person authorized by him to do so?
2. May such prescriptions be telephoned by a physician to a pharmacist, and then written and signed by the pharmacist?
3. May a physician authorize a pharmacist, by telephone, to refill such prescriptions?

Following are excerpts from the opinion:

"It will be desirable to state at the outset the purpose of this legislation. In requiring that the enumerated drugs be sold or dispensed only upon the written prescription of a duly licensed practitioner, the Legislature sought to remedy the mischief of the sale or dispensation of these drugs to improper persons or in harmful quantities, in order to protect the public from addiction thereto.* This purpose must be borne in mind when interpreting the act."

GEM FROM A DISTRICT COUNCILOR'S REPORT

"The 1950 ——— Councilor District meeting was disappointing from the standpoint of attendance but rewarding in its social features. This reflects the keener interest of the older members of our profession in meeting with their colleagues as well as the indifference of the younger members who remain away from such meetings in large numbers. Perhaps they have not yet realized the importance of social contacts and acquaintanceships with the older practitioners who are schooled in the art of medicine." (See page 863, this issue.)

"The duty to prepare such prescriptions is imposed by the statute upon persons specially trained and qualified so to do. The duty is one requiring the professional knowledge or judgment of the persons so qualified, and consequently cannot be delegated to or exercised by a layman."

"Moreover, the preparing of a prescription by anyone other than a licensed practitioner would constitute the unauthorized practice of medicine."

"Bearing in mind the purpose of the Legislature to protect the public, the act must be construed in such a manner as to minimize this hazard. Consequently, the signing of the prescription should be done by the physician himself."

"The unequivocal statutory requirement that the prescription be written would seem absolutely to prohibit a pharmacist's selling one of the

controlled drugs on the sole authority of a telephone conversation. . . . On the other hand, this conclusion should not be construed to prohibit a pharmacist's compounding a prescription on the authority of a telephone call provided he has the opportunity to examine the written confirmation prior to delivering the drug to the buyer."

" . . . Regulation No. 1 promulgated under the Dangerous Drug Act requires a new prescription for each refill in excess of the number of refills specifically authorized by the original prescription."

"Reason demands that the same precaution be taken in the case of refills as in the case of original prescriptions."

"We are, therefore, of the opinion, and you are accordingly advised that before a pharmacist may lawfully sell or dispense any analgesic, hypnotic, or bodyweight reduction drug, as defined



Since 1933 a testimonial plaque has been presented by the State Society to each member who attains fifty years in practice in public expression of the esteem in which each is held because of his "fifty years of medical service to his community and the traditional ideals of the profession." This year seventy-two physicians have been so honored.

Pictured above, left to right, are: Robert O. Koons, Herman A. Fischer, Sr., Daniel G. Robinhold, Charles L. Ashley, and August G. Hinrichs, all from Luzerne County, who were presented with the plaques at the Twelfth Councilor District meeting at the Irem Temple Country Club in Dallas on June 21 by Trustee and Councilor Thomas R. Gagon. A sixth member of the Luzerne County Medical Society to be honored, Patrick A. McLaughlin, was unable to attend the meeting due to illness.

in the Dangerous Drug Act, the Act of July 18, 1935, P.L. 1303, as amended, 35 P.S. Section 940 et seq., whether it be by original prescription or by renewal, he must be in actual possession of a written prescription personally prepared and signed by a duly licensed physician, dentist, or veterinarian. Such prescription may be written by an assistant provided that it is verified by the signature of the practitioner.

C. L. PALMER, *Chairman*,
Committee on Public Health Legislation.

HOME VISITORS' PROGRAM

At the June meeting of the board of directors of the Blair County Medical Society, Dr. H. Fred Moffitt presented to the board an outline of a home visitors' program for cancer patients, and asked the board for endorsement of this program. Dr. Moffitt stated that the American Cancer Society had asked the Blair County unit to start a program for home visiting of cancer patients. This program was initiated with a small unit consisting of 16 women. These 16 were selected from 50 applicants.

The purpose of this program is to train selected individuals to visit cancer patients and help make their days more pleasant and to aid the patients' families when needed.

The 16 women selected for the Blair County unit were given a course of eight lectures as follows:

1. The purpose of the training course; visiting the indigent patient; supplies needed; supplies that can be obtained from the loan closet; instruction that this group give no physical care to the patient.

2. Understanding the cancer patient. (These first two lectures were given by a nurse.)

3. The third lecture was given by a local service worker on home situations; the group was instructed that cancer was not to be mentioned to the patient. A film was shown, "The Cancer Patient in the Home."

4. Duties of the volunteer group; doctor-patient relationship.

5. Home duties.

6. Reading in the home—ceiling projector demonstrated.

7. Cancer — the problem in general — presented by Dr. Moffitt.

8. Report of visits.

Dr. Moffitt stated that these visitors tell the family why they are there, but not the patient. He stated that in the group of Department of Public Assistance (DPA) patients these women had visited, without exception, in every home, they were asked to return. He emphasized that this was purely a voluntary visitors' program. To date only indigent DPA patients have been visited by the group.

Dr. Francis I. Taylor stated that he felt these visitors should not go into a home unless the doctor in charge was consulted first.—*Blair County Medical Society Bulletin*.

THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

Constitution—Article V—House of Delegates

The House of Delegates shall be the legislative and policy-making body of this Society and shall be composed of: (1) delegates elected by the component county medical society in the proportion of one delegate for every 100 or fraction thereof of its active members, as of June 1 preceding the annual session, and who shall be certified to the office of the Secretary-Treasurer of this Society by June 1; (2) the secretaries of the component county medical societies; (3) ex-officio, the president, the president-elect, and the vice-presidents of this Society, the trustees and councilors, secretary-treasurer, assistant secretary-treasurer, ex-presidents of this Society, and the presidents of the component county medical societies, but without the right to vote. In the absence of its secretary, the president of that component county medical society may be seated with the right to vote. The county medical society when electing delegates shall also elect two alternates-at-large for each delegate, who shall also be certified to the office of the Secretary-Treasurer of this Society by June 1.

If any component county medical society is without representation at any session of the House of Delegates, then the members registered in attendance from that county may select from their number one delegate who shall be the representative of that county and who shall serve in the place of an accredited delegate. If but one member is registered, he shall be seated as a representative of that county. When any delegate is once seated, no change may be made in his status during the session. No individual member shall be entitled to more than one vote. The voting membership shall be the delegates duly seated, alternates duly seated as delegates, and the secretaries of the component county medical societies in attendance or their presidents acting as their alternates.

No individual occupying an ex-officio membership in the House of Delegates shall be seated as a delegate with vote, except that, when an ex-president of this Society, who is not at the time a trustee and councilor or other officer, is a regular delegate of his county medical society duly elected to represent it in the House of Delegates, he shall be received as an accredited member of the House of Delegates, and shall have all the privileges of an accredited member during the term for which he was elected.

A CORRECTION

On page 739 of the July issue of the PENNSYLVANIA MEDICAL JOURNAL the names of the district censors in the Third and Fourth Councilor Districts were by error included with the names of members throughout the State who this year received the Society's 50-year testimonial plaque. These district censors have all received a letter expressing regret, as has also Dr. Thomas C. Rutter, of Schuylkill County, who was the only member of the nine county medical societies comprising the Third and Fourth Councilor Districts who, at the combined 1950 councilor district meeting, received the Society's citation "for fifty years of medical service to his community in the traditional ideals of the profession."

BRITISH DOCTORS PROPOSE WITHDRAWAL FROM NATIONAL HEALTH SERVICE

During the summer several members of the State Society have taken trips to Europe and have obtained first-hand information on the operation of the National Health Service in England.

Dr. Jay G. Linn, of Pittsburgh, while visiting in Glasgow observed the following news story in the *Glasgow Herald* of Friday, July 14, which is reprinted here for our readers to illustrate how the British doctor feels towards the service and his patients.

DOCTORS' N.H.S. THREAT

Resolution on Withdrawal

Over 400 doctors at the opening session of the British Medical Association's annual meeting yesterday at Southport supported a resolution instructing the General Medical Services Committee to make immediate preparations for the termination of contracts by general medical practitioners in the National Health Service.

The resolution, to which there was one dissentient, endorsed a resolution of the special con-

ference of local medical committees last month protesting at the "repeated hold-ups and prolonged delays" in negotiations on general practitioner remuneration.

There were cheers when Dr. S. Wand (Birmingham), chairman of the General Medical Services Committee, who proposed the resolution, said of the proposal to withdraw from the service: "That does not mean that we will stop being doctors or stop giving attention to our patients. It means that we terminate our contracts with the Ministry."

Minister "Sympathetic"

The resolution on the termination of contracts said: "The preparations for withdrawal should be put in hand at once and planned in full practical detail, including adequate attention to the public relations aspect."

Dr. Wand said: "I believe that, at this moment, we have considerable sympathy within the Ministry of Health and with the Minister himself. I do feel that the trouble is, at the moment, the Treasury and the Chancellor."

Dr. Charles Hill, M.P., secretary of the B.M.A., warned the conference that from the moment of the mass resignation the doctors might find that the Ministry of Labour had referred the matter to compulsory arbitration and they would "be bound to accept the result."

"We have no desire to make political capital or make things difficult for any political party—we simply want to get a fair deal for the general practitioner," he said. "Now the time seems to have come when we have to have a show-down."

In Patients' Interest

"I hope the whole profession will go forward united and determined because we know that whatever fight we engage in is one not only for the proper treatment of the general practitioner but one for the good of the patient, because without a satisfied general practitioner service there are bound to be reactions, and it is the patient who will suffer."

Dr. Hill said that today about 22.6 per cent of the general practitioners were earning £700 net a year, and 36.4 per cent were earning under £1000 a year. The doctor's share of the total required per person a year for the service was about the price of a cigarette and a match to light it with.

A resolution from Marylebone, London, on the general question of the administration of the

health service complained that doctors, though willing to cooperate with the authorities in building up an efficient and smooth-working health service, had been "frustrated by the cavalier treatment" accorded to representatives in discussions with the Minister of Health.

Dr. R. Hale-White, who proposed this resolution, claimed that the National Health Service was "in a mess and getting worse," and said that the Minister had "plumbed the depths of insincerity." "I don't believe he ever had the slightest intention of cooperating," he added, "once he got the doctors in the bag, but was determined to do just as he liked."

Memorial Criticized

The form and symbolism of the war memorial which the B.M.A. propose to erect at their headquarters in London in memory of the 493 members of the Association who died in the Second World War were sharply criticized. "The figures on it," said one doctor, "are not anatomically decent and do not represent anything we know in the human structure."

Dr. Guy Dain (Birmingham), chairman of the War Memorial Committee, said that he hoped the meeting would allow the proposal to go forward. It was a thoroughly artistic representation.

The meeting decided to postpone their decision on the matter until tomorrow morning to give members a chance to inspect a model of the memorial.

Before adjourning until today the meeting approved a resolution calling for an increase in doctors' remuneration because of the extra expense entailed by the rise in the price of petrol. —*The Glasgow Herald*, Friday, July 14, 1950.

SCHOOL OF AUXILIARY MEDICAL SERVICES

The Board of Trustees of the University of Pennsylvania has approved plans for the establishment of the School of Auxiliary Medical Services, the first of its kind in U. S. medical history. The organization of this school embodies within the University structure a new educational medium which offers programs of study in physical and occupational therapy.

The first two units of the school are to be a Division of Physical Therapy, into which is absorbed the School of Physical Therapy of the Graduate Hospital of the University of Pennsylvania, at 19th and Lombard Streets, Philadelphia, and the Philadelphia School of Occupational Therapy, 419 South 19th Street, which

was merged with the University of Pennsylvania as of July 1, 1950.

In time, the University's announcement said, other divisions may be added to the new school, which would include divisions for other groups of auxiliary medical workers, such as technicians and medical record librarians.

The purpose of the School of Auxiliary Medical Services is threefold: (1) to meet the ever increasing employment demands caused by the rapid expansion of the use of physical and occupational therapy and the recognition of their value in the broad field of rehabilitation; (2) to offer to young men and women, who wish to pursue a career in one of the auxiliary medical services, an opportunity for cultural study and a baccalaureate degree together with basic study, training, and certification in a profession; (3) to enlarge the service of the University to the community and to make the group of schools in the medical sciences still more complete.

Two courses of study are offered in each division of the new school, one an undergraduate program leading to a Bachelor of Science degree and the other a certificate course for persons who already hold a bachelor's degree. During the first two undergraduate years the emphasis is on liberal arts courses. A number of highly specialized science courses basic to specialization are included. The programs in the last two years diverge into the chosen area but run along parallel lines with as much coordination as possible. The curriculum is so developed that consideration of a broad educational background is paramount.

Following the attainment of the degree, students in each division are to have a period of practical experience in hospitals and special institutions in which there are well-organized physical and/or occupational therapy departments designated as clinical training centers. A certificate of proficiency is granted by the school upon successful termination of the clinical training.

Students with advanced standing may transfer into the course any time prior to the beginning of the junior year.

College graduates are admitted for intensive courses in professional preparation which fully qualify them for one of the fields, either physical or occupational therapy.

The school has its own faculty but, as an integral part of the University, can draw upon the almost unlimited resources of the other schools of the University—undergraduate, graduate, and professional—for broadening and enriching its program.

The following faculty appointments as officers of the School of Auxiliary Medical Services became effective July 1:

Wesley G. Hutchinson, Ph.D., dean.

George Morris Piersol, M.D., medical director of the Division of Physical Therapy.

Dorothy E. Baethke, professor of physical therapy and director of the Division of Physical Therapy.

Helen S. Willard, professor of occupational therapy and director of the Philadelphia School of Occupational Therapy.

Clare S. Spackman, associate professor of occupa-

tional therapy and assistant director of the Philadelphia School of Occupational Therapy.

Eleanor J. Carlin, assistant professor of physical therapy and assistant director of the Division of Physical Therapy.

Eleanor Kyle, assistant professor of occupational therapy and assistant director of the Philadelphia School of Occupational Therapy.

This is declared to be the first time in medical history in this country wherein a large university has merged two such schools within the frame work of an organization to be known as a School of Auxiliary Medical Services, and dignified their status with the creation of a deanship and baccalaureate degrees.

The school is now accepting applications for admission and will begin operations with the opening of the new academic year 1950-51 at the University of Pennsylvania in September.

CHANGES IN MEMBERSHIP

New (37) and Reinstated (2) Members

BRADFORD COUNTY: Richard G. Day, Jr., Sayre.

CAMBRIA COUNTY: Donald D. Mitchell, Johnstown.

CLARION COUNTY: Gail W. Kahle, Marienville; David L. Miller, New Bethlehem.

CLINTON COUNTY: Richard S. Clover, Jr., Lamar.

CRAWFORD COUNTY: John H. Bailey, Jr., Meadville; Gerald W. Brooks, Saegertown.

DAUPHIN COUNTY: Richard P. Fitzgerald, Harrisburg.

ERIE COUNTY: Murl E. Kinal and William H. Parsons, Erie.

LACKAWANNA COUNTY: James E. Boland and Salvatore R. Pettinato, Carbondale; William A. MacNamara, Scranton. (Reinstated) John B. Jordan, Scranton.

LUZERNE COUNTY: William F. Connell, Pittston; John M. Koval, Hazleton.

LYCOMING COUNTY: Warren H. Hayes, Williamsport.

MONTGOMERY COUNTY: Raymond M. Andries, Norristown; Walter S. Darby, Conshohocken; Thomas A. Boyd, Ardmore. (R) Matthew J. Zakreski, Philadelphia.

PHILADELPHIA COUNTY: Emanuel Almes, Alfred S. Ayella, Jr., Morton R. Coane, Meyer Edelman, William E. Kelly, Gerald J. Schipper, G. Winston Taylor, Arthur Raymond Thomas, Arthur R. Vaughn, Jr., and Joseph L. Williams, Philadelphia; Richard G. Barker, Drexel Hill; William T. O'Brien, Jr., Paramount, Calif.

SCHUYLKILL COUNTY: William O. Curry, Jr., Ringtown; Earle L. Keeter, Pottsville; Richard F. Zehner, Orwigsburg.

SOMERSET COUNTY: Charles R. Hatfield, Boswell.

TIOGA COUNTY: Robert Stevens, Wellsboro.

VENANGO COUNTY: Manson Brown, Franklin.

Resignations (11), Transfers (8), Deaths (15)

ALLEGHENY: *Deaths*—Daniel A. Atkinson, Jr., Pittsburgh (Univ. Pgh. '35), June 3, aged 39; Myrtle R. Feltwell, Imperial (Univ. Pgh. '04), June 16, aged 71; Charles F. Kutscher, Pittsburgh (Univ. Pgh. '27), June 3, aged 50; William Tomlinson, Seaford, Del. (Univ. Pgh. '02), May 31, aged 80.

BRADFORD: *Resignation*—Alan S. Rubenstein, Le Raysville.

CHESTER: *Resignation*—Russell D. Harris, Phoenixville.

CRAWFORD: *Transfer*—Willis B. McClelland, Cochran, from Venango County Society.

DAUPHIN: *Deaths*—James N. O'Brien, Harrisburg (Georgetown Univ. '30), June 10, aged 44; William J. Albright, Highspire (Jeff. Med. Coll. '22), May 31, aged 53.

DELAWARE: *Resignations*—Adrian V. B. Orr, Helen Rovinski, and Robert G. Stanley, Chester.

LACKAWANNA: *Resignation*—Charles A. Gibbons, Philadelphia.

LAWRENCE: *Death*—Samuel W. Perry, Sr., New Castle (Jeff. Med. Coll. '99), May 9, aged 76.

MONTGOMERY: *Transfer*—Frank E. Boston, Lansdale, from Philadelphia County Society.

PHILADELPHIA: *Transfers* — John E. Hampton, Washington, N. J., to New Jersey State Society; Arnold J. Rawson, Norfolk, Va., to Virginia State Medical Society. *Resignations* — Rebecca Cornfeld-Reiss, Alice Barkan, Joseph H. Smith, and Julius Winston, Philadelphia; John B. Reddy, Annapolis, Md. *Deaths*—Samuel Axilbund, Philadelphia (Temple Univ. '12), May 21, aged 63; Elizabeth L. Ewing, Philadelphia (Woman's Med. Coll. '22), June 4, aged 81; William K. Seibert, Philadelphia (Med.-Chi. Coll. '05), May 17, aged 71; Horace J. Williams, Philadelphia (Jeff. Med. Coll. '12), June 3, aged 65.

POTTER: *Death*—Henry D. Hart, Genesee (Balt. Med. Coll. '93), April 18, aged 89.

SCHUYLKILL: *Death*—Sterling F. Mengel, Schuylkill Haven (Jeff. Med. Coll. '26), June 2, aged 49.

SOMERSET: *Transfer*—Ross S. Rumbaugh, Meyersdale, from Indiana County Society.

WASHINGTON: *Transfer*—George Hamerick, Jr., Ft. Lauderdale, Florida, to Broward County (Fla.) Medical Society. *Deaths*—David H. Edwards, Washington (Eclectic Med. Coll. '03), April 27, aged 71; Arthur V. Donaldson, Canonsburg (Univ. Pgh. '11), June 17, aged 65.

You won't want to miss the color television showings at the Annual Session. See page 824.

WESTMORELAND: *Transfer*—C. Huber Ambrose, New Kensington, from Clearfield County Society.

YORK: *Transfers*—Alfred L. Chicote, Manchester, from Chester County Society; Howard Shaub, Jr., Windsor, from Lancaster County Society.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since May 30. Figures in first column denote county society numbers; second column, State Society numbers.

June	1	Delaware	293-294	9865-9866	\$46.00
		Blair	117	9867	23.00
		Crawford	56	9868	23.00
		Allegheny	1535-1568	9869-9902	782.00
	2	Clinton	26	9903	23.00
	5	Schuylkill	151-154	9904-9907	92.00
		Lackawanna	271-272	9908-9909	46.00
		Butler	66	9910	23.00
		Lackawanna	266-270	9911-9915	115.00
		Delaware	295	9916	23.00
	6	McKean	50	9917	23.00
		Luzerne	360-361	9918-9919	46.00
		Clinton	27-28	9920-9921	46.00
		Huntingdon	25-27	9922-9924	69.00
		Allegheny	1569-1572	9925-9928	92.00
	7	Philadelphia	2840-2954	9929-10043	2,645.00
		Crawford	57	10044	23.00
		Lycoming	136	10045	23.00
		Clinton	29	10046	23.00
		York	167-168	10047-10048	46.00
		Bradford	45-47	10049-10051	69.00
	9	Bedford	10-11	10052-10053	46.00
		Lycoming	133, 135, 138	10054-10056	69.00
		Bucks	86	10057	23.00
		Washington	134-135	10058-10059	46.00
		Somerset	28	10060	23.00
		Northumberland	74	10061	23.00
		Fayette	112-113	10062-10063	46.00
	10	Armstrong	42	10064	23.00
		Lancaster	227	10065	23.00
		Lehigh	222	10066	23.00
		Somerset	29	10067	23.00
		York	169-170	10068-10069	46.00
		Lackawanna	273-277	10070-10074	115.00
	12	Delaware	296-302	10075-10081	161.00
		Jefferson	57	10082	23.00
		Somerset	30	10083	23.00
	13	Washington	136	10084	23.00
		Butler	67	10085	23.00
		Northampton	237	10086	23.00
		Tioga	24-25	10087-10088	46.00
	14	Westmoreland	205	10089	23.00
		Warren	49	10090	23.00
		Clarion	23	10091	23.00
		Somerset	31	10092	23.00
	15	Elk	26-27	10093-10094	46.00
		Chester	115	10095	23.00
	16	Venango	49	10096	23.00
		Cambria	154	10097	23.00

19	Lackawanna	278-283	10098-10103	\$138.00
	Cambria	155	10104	23.00
	Crawford	58-59	10105-10106	46.00
	Lycoming	139-141	10107-10109	69.00
	Montgomery	347 (1949)	10774	15.00
	Montgomery	334-347	10110-10123	322.00
20	Greene	24-25	10124-10125	46.00
	Bucks	87, 89-90	10126-10128	69.00
	Beaver	127-128	10129-10130	46.00
	Dauphin	253	10131	23.00
	Tioga	26	10132	23.00
21	Venango	50	10133	23.00
	Blair	118	10134	23.00
23	Delaware	303	10135	23.00
	Luzerne	362-366	10136-10140	115.00
26	Chester	116	10141	23.00
	Erie	201-202	10142-10143	46.00
	Bradford	48	10144	23.00
	Lackawanna	293 (1949)	10775	15.00
	Lackawanna	284	10145	23.00
	Schuylkill	155-160	10146-10151	138.00
	Clarion	24	10152	23.00
	Philadelphia (1949)		10776	15.00
	Butler	68	10153	23.00
27	Clarion	25	10154	23.00
	Northumberland	75	10155	23.00
28	Venango	45-46	10156-10157	46.00
	Lebanon	73	10158	23.00
29	Elk	23	10159	23.00
	Northumberland	76	10160	23.00

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Do you have any puzzling diagnostic problems to solve or a paper to prepare for professional or lay audiences? If so, why not take advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania?

The library consists of a collection of over 105,000 reprints and tear-sheets from various publications, which are filed for your use. Requests for material should be addressed to the Librarian, 230 State St., Harrisburg, Pa., and a package will be mailed to you for a loan period of two weeks. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material.

The following requests were filled during the month of June:

Multiple sclerosis	Mental tests
The porphyrins	Bronchiectasis
Hematoporphyrinuria	Lung cysts
Maternal mortality	Endocrine glands
Lower nephron nephrosis	Ascorbic acid
Silicosis	Life duration
Brucellosis	Treatment of leg ulcers

Pelvic diseases	Chorionepithelioma
Angina pectoris	Hodgkin's disease
Gynecology	Eosinophilic granuloma
Anesthesia in obstetrics	Infant mortality
Ophthalmology	Cancer manual
Polioomyelitis	Tattooing
Cyanosis	Removal of tattoo marks
Chlorophyll	Schmincke's tumor
Arthritis	Lipoid pneumonia
Atomic energy	Arthrosis
State medical societies	Homosexuality
Choriocarcinoma	Socialized medicine (2)
Xanthomatosis	Rh factor
Treatment of pertussis	Dermatitis exfoliativa
Use of air-conditioning	
Treatment of sterility by radiation	
Preparation for a medical career	
Intravenous mustard gas in therapy of leukemias and Hodgkin's disease	
Use of sulfur in therapy of arthritis	
Diagnosis and treatment of cancer	
Meningococcus meningitis during childhood	
Licensed hospitals in Pennsylvania	

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Tioga County	\$50.00
Woman's Auxiliary, Lehigh County	500.00
Woman's Auxiliary, Venango County	150.00
Woman's Auxiliary, Venango County	
Memory of Mrs. S. W. Sellew	10.00
Woman's Auxiliary, Delaware County	150.00
Woman's Auxiliary, Lancaster County	200.00
Woman's Auxiliary, Wayne-Pike County ...	20.00
Woman's Auxiliary, Lawrence County	75.00
Woman's Auxiliary, Bucks County	150.00
Woman's Auxiliary, Beaver County	
Memory of Mrs. B. B. Snodgrass and Mr. M. R. Glover	20.00
Previously reported	8,843.77
Total	\$10,168.77

ALUMNI DINNER

The Medical Alumni Society of the University of Pennsylvania will hold a dinner at the Hotel Warwick, Philadelphia, at 6 p.m., Wednesday, October 18, in connection with the convention of The Medical Society of the State of Pennsylvania. The dinner will be over in time for the guests to attend the president's reception at 9 p.m. Subscription cards will be sent to all alumni.

SEVEN TYPES OF INFANTILE DRIVERS BELIEVED TO CAUSE TRAFFIC ACCIDENTS

Seven types of drivers who have never matured emotionally cause many traffic accidents, according to an article in the July issue of *Today's Health*.

These infantile driver types and their behavior patterns are described by Marion Gleason, research assistant for the department of pharmacology and toxicology at the University of Rochester, N. Y.:

1. The person who hasn't outgrown the childhood conviction that his wants come first. His parents always sacrificed their own convenience and pleasure to accommodate him. Now he is the middle-of-the-road driver, the double-parker, the horn-blower at intersections.

2. The person who was taught as a child to obey without thinking. He becomes the driver who obeys

signals from other drivers automatically and may drive into intersections or pass other automobiles without thought of other traffic.

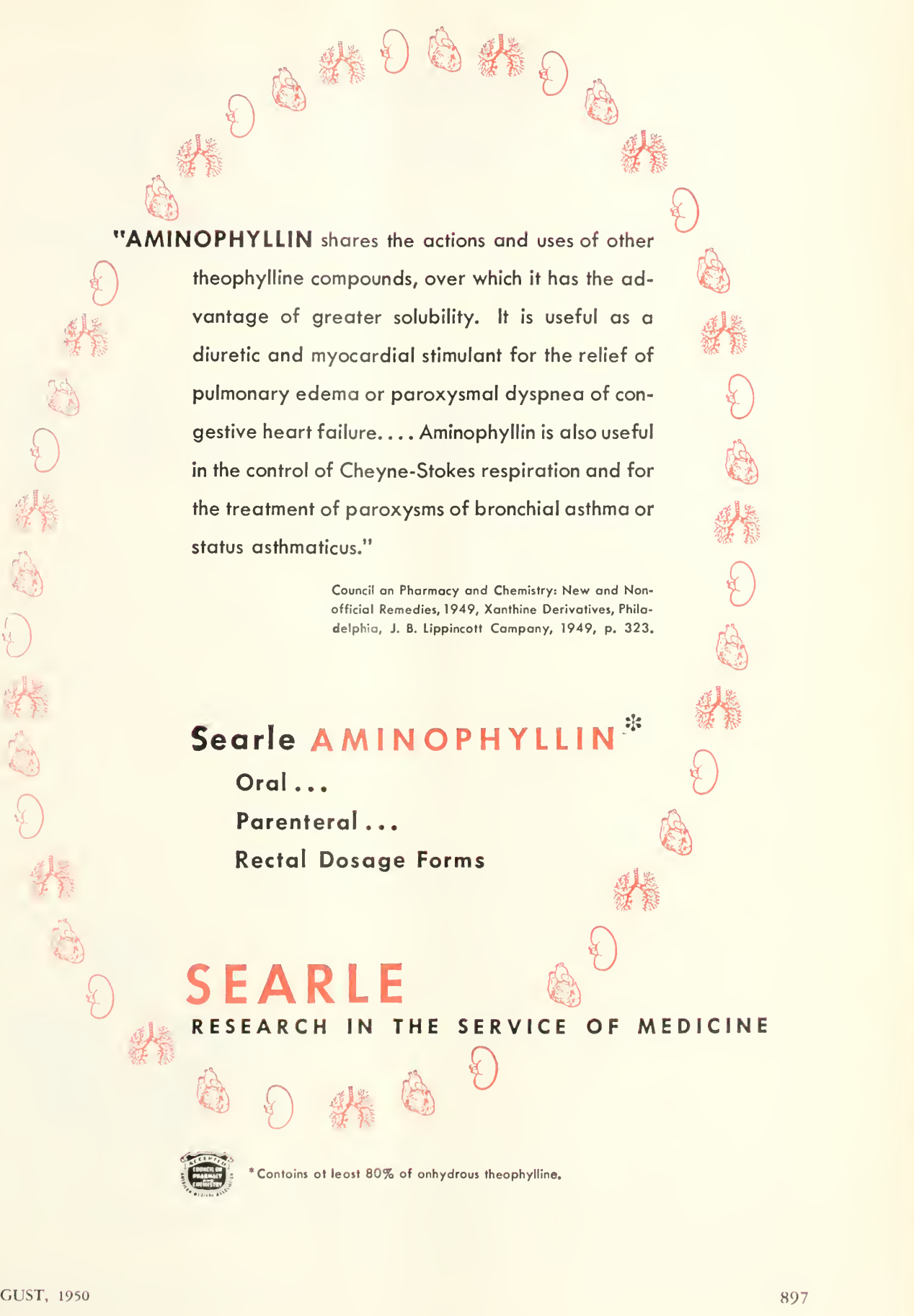
3. The pampered type frequently is a well-groomed and charming woman. As a child she could get what she wanted by fluttering her lashes and shaking her curls and she uses the same technique with policemen to get away with parking by fire hydrants and driving through stop lights. She rarely has an accident, but causes many traffic tangles and occasionally serious crashes.

4. This type was bullied by older brothers and sisters and is the really dangerous driver. He works out his old resentments by speeding and sideswiping other autos.

5. Drivers who were overprotected or severely dominated as children account for a large number of serious traffic accidents. Usually in their late teens or early twenties, they find undertaking responsible adult life difficult. They are show-offs, daredevils, law-breakers.

6. The type who was allowed to get by with wrongdoing. The childhood feeling of guilt may lead them from bad to worse conduct in an unconscious search for guidance they never received. They accept tickets and pay fines cheerfully. The traffic ticket takes the place of a spanking which the child wanted but never had.

7. The type who was poor and had to make second-hand textbooks and used bicycles do. He has to prove to himself that his standard-make model will get there just as fast as the most expensive custom-made automobile. Although he speeds, he is alert and rarely has an accident. The accidents he causes are those of trembling witnesses after he is half a mile up the road.



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Council on Pharmacy and Chemistry: New and Non-official Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

SOME mental reservations seem to exist, both here and in England, as to the value of mass surveys for the detection of tuberculosis in the light of the long waiting lists of patients with positive sputum. While complacency about infectious tuberculosis is shocking, yet there is great virtue in knowing the extent of the problem. The average citizen who finds that he has positive sputum is willing and ready to protect his contacts and to limit his own regimen for the betterment of his health.

A CRITICAL EVALUATION OF MASS ROENTGEN SURVEYS

Mass surveys, however, must not be viewed as the mere taking of pictures if they are to be effective in controlling tuberculosis and in uncovering pulmonary neoplasms. It must be recognized that more is needed than physical equipment, a technician, and a physician-reader. A definite philosophy is required. Because of the infectiousness of pulmonary tuberculosis and the seriousness of bronchogenic carcinoma, all photofluorograms which reveal any characteristics of either should be read as "suspect tuberculosis" and/or "suspect neoplasm."

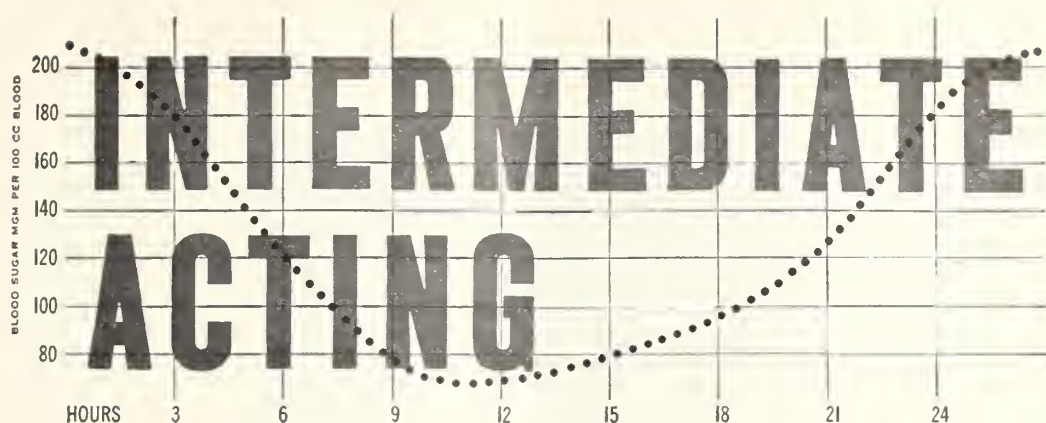
Thus, a significant percentage of patients whose photofluorograms were read as "possible tuberculosis" should ultimately be proved non-tuberculous. For instance, an area of rarefaction should be interpreted as probably advanced tuberculosis although later it is lung abscess. However, no photofluorogram read as non-tuberculous basal infiltration should be found to represent active basal tuberculosis.

Similarly, when a solitary mass, atelectasis, emphysema suggesting obstruction, mediastinal enlargement, soft infiltration or cavity associated with mediastinal shift is found, the survey film should be classified as "suspect neoplasm," especially in middle-aged men. Neither film reader nor clinician should be disturbed if these lesions are subsequently found to be relatively innocuous. If bronchogenic carcinoma is ever to be

conquered, it must be suspected earlier and handled as a medical emergency. Any persistent pulmonary infiltration not definitely diagnosed as tuberculous should be considered potentially malignant just as it is wise to consider all pleural effusions tuberculous until proved otherwise.

Another important aspect of survey work is the population segment to be studied. Only 0.3 per cent of 4059 Philadelphia primary school children surveyed in 1946 were possibly tuberculous. In contrast, 8.4 per cent of 3106 diabetic patients surveyed in 1946 and 2.3 per cent of 32,535 food-handlers surveyed in 1947 showed possible tuberculosis. In 1948, 2.5 per cent of 20,903 Philadelphia industrial workers had a survey reading of possible tuberculosis while, for Philadelphia General Hospital admissions and outpatients, the percentage was much higher, 6.4 per cent.

It has been emphasized that only apparently healthy persons are suitable candidates for surveys. While this attitude is based on the sound premise that persons with signs or symptoms deserve more careful study than a single miniature film, the fact remains that innumerable persons with symptoms do come to survey units for photofluorograms. Many physicians hesitate to refer patients who have respiratory symptoms for careful radiologic study because of expense.



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mediate action without preliminary mixing in vial or
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In 10 cc. vials, U-40 and U-80.

1. Rohr, J.H., and Colwell, A.R., Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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If this situation is recognized, a properly indoctrinated survey staff can surmount the obstacles presented by these persons and their physicians by inquiring about the presence of cough, chest pain, and blood spitting as the film is taken. Frequently this elicits voluntary information about other pulmonary symptoms. These data can be noted on the card so that the physician reading the photofluorograms can add to his "negative" report to the referring physician some such phrase as, "May we call attention to the fact that one miniature photofluorogram does not constitute adequate study in the presence of signs or symptoms." If such persons have no private physician, an explanation can be made of the importance of more careful studies and suitable referral made.

There are even a number of ex-sanatorium patients who have not returned to clinics or physicians for years but who come to surveys. These persons should be interviewed, impressed with the wisdom of periodic checkup, and referred to a physician or chest clinic. This is a service the survey unit can undertake. The relapse rate in tuberculosis continues to be about 50 per cent.

Once the readings have been made, prompt interview of the patients with suspected disease is essential. Even an intelligent person may not go promptly to a hospital or chest specialist if the suggestion is made weeks after the taking of the photofluorogram. If a film appears to be of grave significance, the patient should be sent for at once and, if possible, hospitalized immediately. This means personal effort on the part of the survey physician. Such major decisions and vigorous action cannot be taken by clerks nor even by public health nurses. The interview with the patient whose photofluorogram is considered significant should be made by a physician who can explain the photofluorogram to the patient and answer questions authoritatively.

The interview must be conducted with the greatest consideration. To avoid prolonged anxiety, the appointment letter should arrive the day before the interview and should state only that

the physician has set the date "to talk over the x-ray." It requires considerable experience to gauge the approach which will impress persons sufficiently to induce immediate appropriate action without disproportionate anxiety.

In the early days of the program when patients were referred to their physicians after the interview with the statement that the physician would receive a report, about 20 per cent failed to report. By the simple expedient of handing them a note on which is written their name, the name of the physician or clinic to which they are to go, the date, and a brief, carefully worded report of survey findings, almost 100 per cent response was obtained. Like children, with a paper in hand to be delivered, they had some compulsion to complete the job.

Surveys are merely gestures unless adequate follow-up is an integral part of the survey program. Theoretically, once the person reaches the physician or clinic, the survey task has been completed. Some clinicians, however, fail to study survey cases adequately. Standards for follow-up examination of survey patients should include at least the taking of serial films and sputum studies, including culture. If sputum is not available and the possibility of activity is real, cultures of the gastric washings should be made. Facilities for tuberculin testing should be available.

It is the responsibility of the survey team to check on follow-up for the sake of the patient, the protection of the community, the education of the physician, and the perfection of the survey reader.

Annual roentgenograms of the chest for all adults is a feasible goal. Because bronchogenic carcinoma is found too rarely in a curable stage, it is urged that men over 45 be surveyed every six months.

A Critical Evaluation of Mass Roentgen Surveys, Katharine R. Boucot, M.D., and David A. Cooper, M.D., Philadelphia, J. A. M. A., April 22, 1950.



TEMPLE UNIVERSITY

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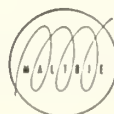
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PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Breast Self-Examination

Women are expected to endorse heartily a new film titled "Breast Self-Examination" and then ask doctors to teach them the correct examination technique.

The "movie" points out to women the importance of examining their own breasts once a month, using a pattern after that which their doctor employs, to see if a lump is present. The examination requires only a few minutes. The "movie" suggests that, by making the examination a monthly health routine, literally thousands of women can assist in the saving of their own lives.

The film was produced by the American Cancer Society and the National Cancer Institute of the U. S. Public Health Service. It has received the enthusiastic approval of the Committee on Medical Motion Pictures of the American Medical Association. At present it is being reviewed by The Medical Society of the State of Pennsylvania. Soon the Pennsylvania Division, American Cancer Society, will release it to the county units with the requirement that approval of county medical societies be sought before it is shown to women's organizations.

The American Cancer Society says that breast cancer develops in about 50,000 women each year. The disease claims over half of them in the first five years. But 80 to 90 per cent of the women could be cured by surgery if cancer was discovered in an early stage.

Since it would seem impractical for women to visit their doctors every month, an effective way to discover a suspicious condition in the breast is by self-examination. Any woman may discover a newly formed tumor when it is but half an inch in diameter. Every woman can and should enjoy the peace of mind and satisfaction that come from safeguarding her own health.

"Breast Self-Examination" gives encouraging reassurance. It points out that about two-thirds of all breast lumps are not cancerous and that only a physician can decide.

The new film is considered so important that the September issue of *McCall's Magazine* will have a feature story on it with illustrations of the breast self-examination technique.

After review by the medical society, the movie will be available through county units of the Pennsylvania Division, American Cancer Society.

Facts

The cancer death rate is of grave concern to Pennsylvania, one of the most populous and prosperous states in the Nation. The latest report from the Bureau of Vital Statistics of the State Department of Health shows that 10,112 Pennsylvanians died of cancer in the first eight months of last year.

An independent voluntary organization concerned with health problems looked at the cancer problem and came forth with a number of interesting observations.

There were only 15 special cancer hospitals having 1492 beds registered by the American Medical Association in 1949. In addition, there were five related institutions (such as nursing homes and infirmaries, which gave certain medical and nursing care) with 718 beds.

There are about 129 cancer detection centers approved by the American College of Surgeons (for people with no apparent symptoms) in the United States, or one detection center to every 1,120,000 people.

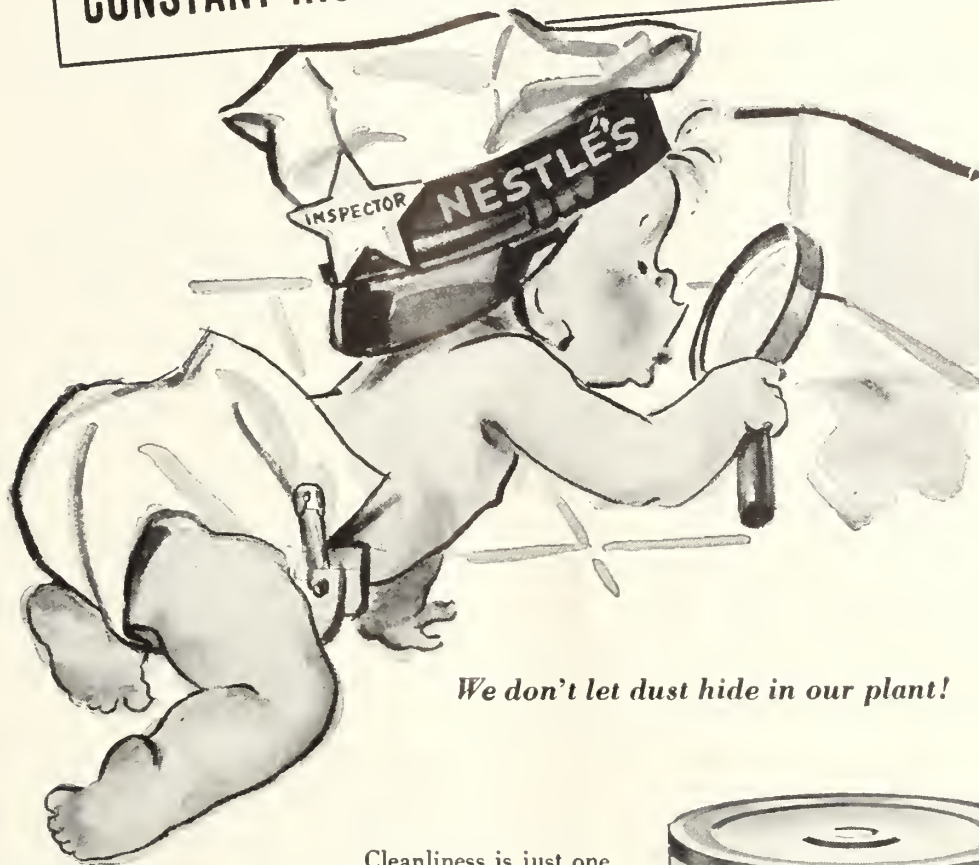
There are about 503 approved cancer treatment and diagnostic clinics, of which 74 are cancer diagnostic (only) clinics, in the United States.

About \$12,938,898 was available in the past fiscal year for research to find new treatments and cures for cancer. The National Cancer Institute, United States Public Health Service, and the Atomic Energy Commission had government appropriations of approximately \$7,781,398. Voluntary agencies allocated about \$5,157,500. This means that we are spending about \$65.67 per cancer death annually, or \$21.56 per known case.

As an interesting side light—Congress authorized the expenditure of \$45,889,811 by the Department of Agriculture in 1949 for the campaign of control and eradication of foot-and-mouth disease in Mexico in cooperation with the Mexican government.

Several interesting exhibits on cancer will be included in the Scientific Exhibit at the Annual Session. Do not leave Convention Hall without visiting them.

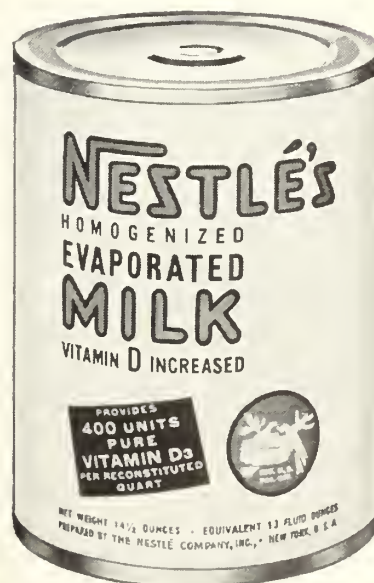
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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street, Indiana

ON TO CONVENTION!

The Woman's Auxiliary to the Philadelphia County Medical Society is busily making plans for the convention this fall of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania. The meetings will be held from October 15 to 19 inclusive. Headquarters will be the Bellevue-Stratford Hotel at Broad and Walnut Streets, Philadelphia 2, Pa.

Mrs. Hugh Robertson, 310 Winding Way, Merion, Pa., and Mrs. Hugh McCauley Miller, Accomac Road, Wyncote, Pa., are serving as co-chairmen for the convention. Already more than 50 per cent of the Philadelphia Auxiliary members have volunteered to serve on the various committees and to aid with registration.

Pittsburgh, the western Pennsylvania convention city, and the Allegheny County Woman's Auxiliary last September provided excellent meetings and entertainment. It is the aim of Mrs. Frank B. Lynch, Jr., president of the Philadelphia County Auxiliary, and of Mrs. Drury Hinton, state president and a member of the neighboring Delaware County Auxiliary, that Philadelphia, as the eastern convention city, will meet the challenge.

At this time final dates and places for the social gatherings have not been definitely arranged. Present plans call for an outing at Longwood Gardens with luncheon at the Kennett Square Country Club. Longwood Gardens is one of the DuPont estates famed for its fabulous horticultural displays, fountains, and outdoor theater. The gardens and greenhouses are beautiful at any time of the year, and the drive from Philadelphia through the rolling hunt sections of Delaware and Chester counties in October is breath-takingly lovely.

There will be luncheons, breakfasts, and teas on other days during the convention. All will be held either at the Bellevue-Stratford or other central city hotels. Since educational and business affairs are the main features of the convention, the chairmen are endeavoring to arrange the social functions in such a manner as to pro-

vide variety in menu and scenery. The doctors' Committee on Arrangements will be very grateful if the membership of the Woman's Auxiliary will strive to arouse preliminary interest in attendance at the opening meeting of the convention—the annual religious service, which is to be held this year in Irvine Auditorium on the University of Pennsylvania campus at 34th and Spruce Streets on Sunday, October 15. A complete program of events will be announced in the September PENNSYLVANIA MEDICAL JOURNAL.

There are always leisure moments when attending a convention, particularly for members who are not officers or delegates. Philadelphia offers a wide variety of attractions to spend these moments advantageously.

Shopping is usually first on any woman's list when relieved of the cares and responsibilities of managing a home. This is not a Chamber of Commerce release, but most all department stores and specialty shops are conveniently located along Chestnut Street between 9th and 17th Streets.

The many museums located in Philadelphia are well worth a visit. The University Museum on the University of Pennsylvania Campus at 33rd and Spruce Streets, near Convention Hall, is famed for its archeologic collection. On the Benjamin Franklin Parkway stretching from City Hall at Broad and Market Streets to the Art Museum overlooking the Schuylkill River, one may visit along the way the Academy of Natural Science, the Franklin Institute in which the Fels Planetarium is housed, the Rodin Museum, and one of the many public libraries in the city.

In downtown Philadelphia, within an area of a few blocks, many historic shrines may be visited. These include beloved Independence Hall, Carpenter's Hall, Christ Church, and the Betsy Ross House.

Fairmount Park in October will be a riot of color in gold, red, and bronze autumnal foliage. Many of the mansions on the bluffs overlooking the Schuylkill River and in downtown Philadel-



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phia have been beautifully restored and are open to the public.

This is but a brief outline of things to see and places to visit between meetings of the convention. Perhaps just a brief moment at our historic shrines will provide each individual visitor with the inspiration and courage necessary to carry on the fight against state medicine.

May the members of the Woman's Auxiliary to the Philadelphia County Medical Society look forward to welcoming all members of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania in Philadelphia in October?

(MRS. JOHN H.) MARION R. WILLARD,
Philadelphia County.

COUNCILOR DISTRICT MEETINGS

As chairman of councilors for the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, I wish to present the following report of the councilor district meetings, all of which I attended and addressed, as the Auxiliary's delegated representative during the current year, except that of the Fifth District. This was attended by our first vice-president, Mrs. J. Frederic Dreyer, because of a conflict of dates with the Sixth District meeting.

First of all, I wish to state that at each meeting I was well aware of the significance of our Auxiliary pledge, "I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals," and how it was being conscientiously observed and promoted by our loyal auxiliary members. The gracious addresses of welcome and the equally gracious responses were heart-warming. The excellent county reports, including that of newly reorganized Jefferson County Auxiliary, showed sincere support of the state auxiliary program. The loyal service rendered by the district councilors, who assisted with the planning, preparation, and promotion of these splendid programs, proved to me that their duties and responsibilities are being undertaken seriously. The harmonious and congenial relationship between the Medical Society and the Auxiliary was everywhere in evidence. The marked interest and enthusiasm of county officers and chairmen in securing instruction, guid-

ance, and answers to their numerous questions was salutary, gave opportunity for the presentation and discussion of new ideas, and showed admirable devotion as well as all-round good service to our auxiliary cause. The district censors' reports presented interesting information to the auxiliary members on the progress being made by the medical societies.

The average attendance at the district meetings was 35 members, with 81 members the largest number registered at any meeting. The attendance in all districts is still considerably below that of auxiliary membership, which is difficult to understand, considering the excellent programs offered at these meetings, with streamlined workshops, lively question and answer periods, and good publicity in local newspapers, as well as in the county medical society bulletins and in the PENNSYLVANIA MEDICAL JOURNAL.

The visiting dignitaries in attendance at these district meetings were E. Roger Samuel, M.D., president of The Medical Society of the State of Pennsylvania; Harold B. Gardner, M.D., state president-elect; Walter F. Donaldson, M.D., state secretary-treasurer; trustees and counselors—Drs. Leard R. Altemus, Gilson Colby Engel, Frank A. Lorenzo, John J. Sweeney, and James L. Whitehill; and Mrs. J. Frederic Dreyer, first vice-president of the State Auxiliary.

The district councilors presided at the meetings and were assisted by county medical society and auxiliary presidents and designated officers and chairmen. The formal programs consisted for the major part of testimonial dinners, with presentations of awards honoring doctors having 50 years of service to their credit; discussions of the medical benevolence fund, public health legislation, National Education Campaign, and public welfare; vigorous opposition to political medicine, and making plans for 1950-51.

The First Councilor District meeting, with Mrs. Francis F. Borzell, district councilor, in charge, was held in the Medical Society Building in Philadelphia on March 29 with a combined dinner meeting of the medical society and auxiliary, featuring 50-year awards. Speakers were Drs. E. Roger Samuel, Gilson Colby Engel, and Francis F. Borzell.

The Second Councilor District meeting, with Mrs. Elmer H. Bausch, district councilor, in charge, was held in the Berkshire Hotel, Reading, on May 10. A separate auxiliary session featured county presidents' report, plans for

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better auxiliary attendance, a continuing program of community health education, cooperation with local health agencies, opposition to compulsory health insurance designed for bureaucratic control, public health needs, poster contests, and the medical benevolence fund. A combined luncheon meeting of the medical societies and auxiliaries was held, with Drs. E. Roger Samuel and John J. Sweeney and Mr. Gar Young, eastern district field representative of the MSSP Public Relations Committee, as the speakers.

A combined meeting of the Third and Fourth Councilor Districts, with Miss Mary Henry Stites, Third District councilor, and Mrs. William J. Jacoby, Fourth District councilor, in charge, was held in the Hotel Bethlehem, Bethlehem, on April 13. A separate auxiliary session featured county reports. A combined luncheon meeting of the medical societies and auxiliaries was addressed by Drs. E. Roger Samuel, John J. Sweeney, Francis J. Conahan, and Charles V. Hogan, and Mr. Leo E. Brown, executive assistant of the MSSP Public Relations Committee.

The Fifth Councilor District meeting, with Mrs. Frank J. Corbett, district councilor, in charge, was attended by Mrs. J. Frederic Drey-

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er, first vice-president of the State Auxiliary. Held in Caledonia Park on May 18, it was a combined luncheon meeting of the medical societies and auxiliaries. Mrs. Dreyer and James Z. Appel, M.D., held a question and answer period.

The Sixth Councilor District meeting, with Mrs. Ralston O. Gettemy, district councilor, in charge, was held in the Nittany Lion Inn, State College, on May 18. County reports were given at a separate auxiliary session. The medical societies and auxiliaries held a combined dinner meeting and dance. Drs. E. Roger Samuel, Harold B. Gardner, and Robert F. Banks were the speakers.

The Seventh Councilor District meeting, with



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Mrs. Harry W. Buzzerd, district councilor, in charge, was held in the Woman's Club, Williamsport, on May 3. Following the luncheon, county reports were given, and speakers included Drs. Harold B. Gardner and George S. Klump, Mr. Leo E. Brown, and Miss Suzanne Treadwell, staff assistant of the MSSP Public Relations Committee.

The Eighth Councilor District meeting, with Mrs. Mary Harker Jones, district councilor, in charge, was held in the Riverside Hotel, Cambridge Springs, on May 25. Mrs. Albert F.

Doyle, state legislation chairman, and your president-elect were the speakers at the meeting which featured an original program and workshop with round-table discussion and a question and answer period on public health legislation.

The Ninth Councilor District meeting, with Mrs. Robert S. Lucas, district councilor, in charge, was held in Punxsutawney at the Country Club on June 15. An auxiliary session included county reports, a round-table conference, a question and answer period, and a preview of the coming year's work. A combined luncheon meeting of the medical societies and auxiliaries featured a 50-year award with Frank A. Lorenzo, M.D., and Mr. Keith Hutchison, western district field representative of the MSSP Public Relations Committee, as speakers.

The Tenth Councilor District meeting, with Mrs. Hubert J. Goodrich, district councilor, in charge, was held in Schenley Hotel, Pittsburgh, on June 8. A separate auxiliary session featured county reports and discussion of the National Education Campaign. Speakers at a combined luncheon meeting were Drs. E. Roger Samuel, Harold B. Gardner, and James L. Whitehill, Mr. Leo E. Brown, and Mr. Keith Hutchison.

The Eleventh Councilor District meeting, with Mrs. Joseph E. Shelby, district councilor, in charge, was held in the George Washington Hotel, Washington, on June 8. A combined meeting of the medical societies and auxiliaries, with a radio broadcast, featured 50-year awards and Drs. Louis W. Jones, first vice-president, MSSP, and Leard R. Altamus, and Mr. Keith Hutchison as speakers.

The medical societies of the Twelfth Councilor District are having a meeting on June 21 and have invited their auxiliaries to attend.

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GYNECOLOGY—Intensive Course, two weeks, starting September 25. Vaginal Approach to Pelvic Surgery, one week, starting September 18.

OBSTETRICS—Intensive Course, two weeks, starting September 11.

MEDICINE—Intensive General Course, two weeks, starting October 2. Gastro-enterology, two weeks, starting October 16. Gastroscopy, two weeks, starting September 11 and October 23. Electrocardiography and Heart Disease, four weeks, starting October 2.

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able to attend these district meetings, I wish to re-emphasize that the Auxiliary is like time—always moving forward. It goes on regardless of obstacles. In 25 years nothing has stopped it. The auxiliary program is like a watch. If it is in good working order, things run smoothly and no one loses time. But sometimes our watches slow down, and at other times they run too fast. Is your auxiliary watch ticking smoothly? Has your program slowed down? Is it going too fast in places? Can we help you to regulate your auxiliary watch so that every minute is made to count? You can put your watch in good running condition—you can enjoy yourself at the same time that you are doing a much needed and worth-while job for the Auxiliary. Each one of us represents a unit of community activity; the doctor and his family are of importance and service not only to their own families but to their communities and their nation as well.

(Mrs. Howard H.) MARY STEEL HAMMAN,
President-elect.

WHEELS TURNING

Before our auxiliary wheels slowed down a bit for the summer months, twelve counties reported their year-end activities.

BERKS—On Monday, May 8, the twenty-fifth year came to a close. Mrs. David B. Allman, national president, was the guest of honor, and several state officers and chairmen, members from neighboring auxiliaries, and thirteen past presidents attended the luncheon. Musical entertainment was provided by two Albright College students—Miss Ethel Harris, soprano, and Miss

Janet Tomkins, accompanist. After the president's annual report was read, the gavel was handed to Mrs. Herman F. Kotzen, incoming president.

A health poster contest was conducted. Open house was in Medical Hall, Reading, on May 14, when all the posters were exhibited. Judging was May 17.

The results of a questionnaire were tabulated. The majority of the members prefer Monday afternoon meetings; a discussion of pertinent current topics, followed by a social hour; continuation of the president's letter; the present editorial trend in the medical society's county bulletin; a formal dinner dance for the benefit of benevolence; a health day; and a booth at the Reading Fair.

BUTLER—A luncheon meeting was held in June at the Butler Country Club to celebrate the silver anniversary. Charter members of the group reviewed the history of the organization and its activities, beginning with the minutes of the first meeting held in the home of Mrs. L. L. Doane on May 21, 1925. Guest soloist for the afternoon was Miss Elizabeth Vargo, with Miss Val Jean Feich as her accompanist.

CLINTON—On May 23 the retiring president, Mrs. William C. Long, entertained at the Fallon Hotel, Lock Haven. Officers were elected. The health posters entered in the contest were shown to the members. There were 25 entries and a committee of art teachers in the county schools judged the posters. Those schools participating were St. Joseph's High School, Renovo; Renovo Public Junior High School; and St. Agnes Grade School, Lock Haven. Prizes were awarded and other entrants each received a dollar and honorable mention as an incentive for another contest next year.

Mrs. Raymond A. Werts reported on the councilor district meeting held in Williamsport in May.

Sixteen members were entertained at the Renovo Country Club, near Hyner Lookout, June 29, by the new president, Mrs. Raymond A. Werts. It was a social affair to interest new members in the work of the auxiliary.



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DAUPHIN—A luncheon meeting was held on March 7 in the Assembly Room of the Penn-Harris Hotel, Harrisburg. James Z. Appel, M.D., Lancaster, trustee and councilor of the Fifth District, MSSP, spoke on "What Is New About Cancer," and Miss Suzanne Treadwell, of the MSSP public relations staff, spoke on "The Inside Story."

A dessert bridge was held at the Academy of Medicine, Harrisburg, on April 11.

The twenty-fifth anniversary was observed on May 2 at the Academy of Medicine. Thirteen past presidents were honored at the luncheon, and a memorial service was conducted for three other past presidents. Musical

entertainment was presented by Michael Rosenberger, tenor, accompanied by Robert Clippinger at the piano.

ERIE—Fifty members were present at the May meeting, a luncheon at the Pussy Willow, Erie. Mrs. Mary Harker Jones, Eighth District councilor, spoke briefly, and Mrs. J. Gilbert Reed reviewed *The Pink House* by Nellia Gardner White.

A luncheon at the Lake Shore Golf Club, Erie, was held on June 5. The newly elected and appointed executive board took office and yearly reports were given. Bridge was played.

INDIANA—Mrs. Frederick J. Kellam, retiring president, entertained the members at her home on Punxsutawney Road, Indiana, in June. Yearly reports were given and the newly elected officers were installed. The sum of \$110 was given to the medical benevolence fund.

LEHIGH—The May meeting featured the election of officers and a reception for 22 new members; \$500 was given to medical benevolence. Mr. Clyde Bishoff, handwriting analyst, addressed the group.

The new officers were installed by Mrs. Charles F. Johnson, a past president, at a luncheon meeting on June 13 at the Lehigh Valley Shrine Club, Allentown. Mrs. Asher G. Kriebel, Lynnville, retiring president, gave a report of her year's administration. The auxiliary presented her with a gift. A musical program was presented and included Mrs. Lewis J. Leiby, lyric soprano of Slatington, accompanied by Mrs. Clarence



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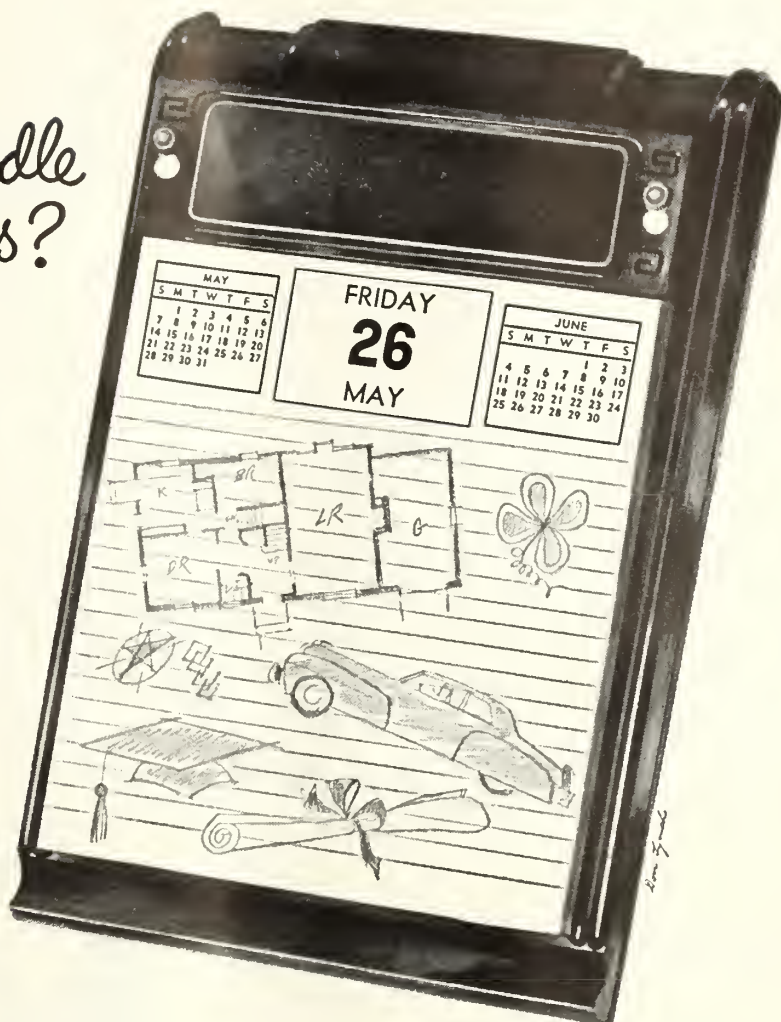
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A. Holland, and a vocal trio composed of Mrs. Ray W. Pickel, Mrs. Marian Thomas, and Mrs. Ammus Evans, all members of the Slatington Music Club, accompanied by Mrs. Robert Beitel, Jr.

LYCOMING—Fifteen members were present at the June 9 meeting held at the Williamsport Country Club. A poster contest had been held and awards were presented by Albert F. Hardt, M.D., at the Curtin Junior High School. Mrs. Spencer Servoss was welcomed into the auxiliary. Mrs. J. Carl Baier assumed the duties of the president. The sum of \$275 was set aside for the nurses' scholarship fund.

NORTHAMPTON—Thomas H. A. Stites, M.D., Nazareth, spoke at a May dinner meeting at the Northampton County Country Club, Easton.

Officers were installed at a joint meeting with the medical society on June 20 at the Northampton County Country Club. Dr. James L. Dyson, professor of geol-

ogy at Lafayette College, addressed the group and showed a scientific motion picture on "The Present Ice-Age."

Members were invited to a testimonial dinner for William L. Estes, Jr., M.D., held on June 1 at the Hotel Bethlehem, Bethlehem.

PHILADELPHIA—The last meeting of the 1949-50 year was held in May in the Mirror Room of the Warwick Hotel, Philadelphia. A contribution of \$375 was made to the Philadelphia Aid Association, this bringing total contributions for the year to \$2,000. Mrs. William A. Shannon, retiring president, installed the new officers.

SCHUYLKILL—A joint dinner meeting and card party of the north and south branches was held at the Schuylkill Country Club on June 15. Officers for the coming year were installed by Mrs. William J. Jacoby, Fourth District councillor.

WARREN—On April 18 a meeting was held at the home of Mrs. Robert H. Israel, North Warren. Speakers were Mrs. Mary Harker Jones, Eighth District councillor; Mr. Keith Hutchison, western field representative of the MSSP Public Relations Committee; and Mrs. William Vogt, who gave a talk on "Old Homes in Warren County," illustrating with colored slides and photographs some homes and churches built in the years 1830-1860. Tea was served.

The May meeting was held at the home of Mrs. Quay A. McCune. Officers were elected and a successful auction was held to raise money for charitable projects. Yearly reports were also given. Dinner was served.

Through the column, "Wheels Turning," you have

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followed the progress of various county auxiliaries. We thank those members responsible for news from the contributing counties. We are sorry that during the past year every county's news was not included, for it was not reported to the editor.

Will each incoming county president please instruct her publicity chairman to send all news to the editor as soon as possible? In this way we can share our experiences with our readers and as a result help to keep our auxiliary wheel in constant motion.

M.D.—THE U. S. DOCTOR

A documentary film depicting the state of our nation's health and produced by Louis de Rochemont was previewed in San Francisco at the Esquire Theater, first-run San Francisco house at 934 Market Street, simultaneously with the ninety-ninth annual meeting of the American Medical Association.

The film, called "M.D.—the U. S. Doctor," stages another *first* for Louis de Rochemont and his trail blazers, producers of "Lost Boundaries," which was cited as one of the ten best films of 1949, and other major award-winning hits.

The new film, to be released nationally in September, is the featured subject in the new film series which will appear in motion picture theaters across the nation as the "*Reader's Digest* on the Screen." It contains the same ingredients which have made *Reader's Digest* the most widely circulated magazine in the world (with 59,000,000 readers).

"M.D.—the U. S. Doctor" is primarily a report on

our nation's health. It records medical progress, pointing out that babies born today will live 18 years longer than those born at the turn of the century. The workings of the new "wonder" drugs, the new medical techniques—all are spotlighted through the rich fund of material gathered by the *Reader's Digest* with the collaboration of the American Medical Association.

The film is the most definitive, most up-to-date motion picture about medicine ever produced. Never before have medical men allowed cameras to investigate so searchingly the secrets of their laboratories and examining rooms. The result is an engrossing experience. For all those interested in health—as all are—it also is a message of hope, tempered with objectivity.

Producer Louis de Rochemont, "maverick of the movies," finds romance in the documentation of real people. Since early in his career, he has filmed a series of photographic explorations into the lives of professional men. Formerly producer of "March of Time," he filmed "Men of Medicine" in that series. Other de Rochemont hits with professional portrayals were "Boomerang," "House on 92nd Street," and "Fighting Lady."

In making this new film, de Rochemont felt that he was repaying a debt to the medical profession. Sixteen years ago, the life of his son, then a small child, was saved through medical knowledge and a "wonder" drug.

De Rochemont also carried through his belief in the responsibility of motion pictures. As he phrased it: "Motion pictures can be an incredibly powerful and strangely universal force for good. Whoever practices the art of picture making has a responsibility to utilize his medium not only to make men laugh and cry and cheer but also to make men think."

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All of this he accomplishes in a 39-minute film using 14 voices.

"M.D.—the U. S. Doctor" points out that never before have so many people had such good medical care as Americans enjoy today. Week by week, new discoveries of the greatest implication are being published in newspapers and magazines. Many of these medicines and medical techniques have a direct bearing on the great disease areas which in the past have plagued all mankind. Already cancer, tuberculosis, diabetes, rheumatism, heart disease, and polio are beginning to yield. The wide field of mental health also is being explored thoroughly.

To pictorialize what doctors themselves are doing to provide better medical care, de Rochemont built much of the film around the work of George Bond, M.D., a real 34-year-old general practitioner in the mountain village of Hickory Nut Valley, North Carolina. The film points out that the majority of doctors are general practitioners—doctors of medicine to a neighborhood or community—and that today the general practi-

tioner in a rural area can cover more miles in a single day than the horse-and-buggy doctor could in a week.

"M.D.—the U. S. Doctor" points out that typical of these general practitioners is handsome young Dr. Bond, who works 18 hours a day solely for the more than 700 families in his mountain area. He alone treats all their diseases. His patients also are his friends and neighbors.

The film shows that, like nine out of ten practicing American physicians, Dr. Bond is a member of a county medical society. These county medical societies, linked together into state and territorial medical societies and one national organization—the AMA, the American Medical Association, in Chicago—make it possible for Dr. Bond and 147,000 other American M.D.'s to share quickly in the knowledge of new medical discoveries.

In the three-and-one-half reel film, producer de Rochemont reveals how the AMA constantly is contributing to the health of the American people—through its twice-yearly national conventions, where thousands of doctors literally go through a five-day postgraduate course, and where its democratic House of Delegates elects officers and determines the policies of the national organization—through publication of the *Journal of the AMA*, numerous specialized scientific journals, and the popular magazine, *Today's Health* (formerly known as *Hygeia*)—through the comprehensive services of the AMA's nine councils, eight bureaus, and seven committees.

This de Rochemont documentary also traces a young medical student, Edwin McGee, through seven years of medical school, then follows him—as a young M.D.—through internship and residency in one of the modern American teaching hospitals and medical centers which have helped raise the standards of medical practice in the United States and throughout the world. Student doctors from a score of nations, the film points out, now come to the United States to complete their education.

At the end, the film reminds the audience that although all American physicians have at their command all the latest knowledge of 20th Century medicine, the kind of care their patients receive depends on the doctor himself. The film's closing words are:

"In the lives of all men and women who practice medicine is realized the noblest of human aspirations. For long ago it was said that in no other act does man approach so near the gods as when he is restoring the sick to the blessings of health—and prolonging life yet a little longer."

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This course will be given annually, the first session to be from Monday, September 25, through Friday, September 29, 1950. The tuition fee will be \$100.00 to physicians in general; alumni of the Graduate School of Medicine are exempt and pay only a registration fee of \$10.00. All fees are payable on application. Full information and application forms may be obtained through the Office of the Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia 4, Pennsylvania.

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MEDICAL NEWS

Births

TO DR. AND MRS. THOMAS R. UBER, of New Castle, a son, June 6.

TO DR. AND MRS. THOMAS R. WILSON, of Ellwood City, a son, June 6.

TO DR. AND MRS. W. HENRY RUSSELL, of Philadelphia, a son, Peter Robinson Russell, July 9. Mrs. Russell is the daughter of Dr. and Mrs. Thomas M. McMillan, of Philadelphia.

Engagements

MISS DENE PARKER, daughter of Dr. and Mrs. Paul H. Parker, to Mr. John R. Roberts, Jr., all of Jenkintown.

MISS KATHERINE BERNICE HUVER, of Malvern, to Mr. Robert F. Sabol, son of Dr. and Mrs. John G. Sabol, of Philadelphia.

MISS JOAN H. KOCEVAR, daughter of Dr. and Mrs. Martin F. Kocovar, of Steelton, to Mr. William H. Spooner, of Bethlehem.

MISS GLORIA ROTH, of New York, to Melvin L. Bernstine, M.D., son of Dr. and Mrs. J. Bernard Bernstine, of Bala-Cynwyd.

MISS CLARA MELISSA MARSH, of Haverford, to Mr. Joseph Evans Sands, 3d, son of Dr. and Mrs. Joseph E. Sands, 2d, of Rosemont.

MISS SUSANNE PHILLIPS, daughter of Dr. and Mrs. Thomas W. Phillips, of Media, to Mr. Miles Martin Isaacs, Jr., of Georgetown, Del.

MISS ANNE MOFFLY LANDENBERGER to Mr. Thomas Williams Smyth, son of Mrs. Williams Smyth and Calvin M. Smyth, Jr., all of Philadelphia.

MISS NANCY ROSS SKILLERN, daughter of Dr. and Mrs. Samuel R. Skillern, Jr., of Cynwyd, to Mr. Robert Garrison Lee, of Maplewood, N. J.

MISS AMY AUSTIN, daughter of Dr. and Mrs. J. Paul Austin, of Barren Hill, to Mr. John Brockie Lukens, son of Dr. and Mrs. George T. Lukens, of Conshohocken.

MISS DUFFY D. WESTON, of Lexington, Ky., to William A. Brodsky, M.D., of Philadelphia. Dr. Brodsky is now a research-fellow at the Children's Hospital, Research Foundation, Cincinnati, Ohio.

Marriages

MISS SARA GORDON SPICER, of Gettysburg, to Vincent J. Lezek, Jr., M.D., of Pittsburgh, July 15.

MISS PEGGY JEAN WARNER, daughter of Dr. and Mrs. Harold R. Warner, to Mr. Harold F. Stoudt, all of Kulpville, June 24.

MISS SHIRLEY ARNOLD, of Aldan, to David W. Thomas, Jr., M.D., son of Dr. and Mrs. David W. Thomas, of Lock Haven, May 12.

MISS MARY ELIZABETH ROMIG to Mr. Robert Bruce McKinstry, son of Dr. and Mrs. Herbert S. McKinstry, all of Kennett Square, July 1.

MISS HEIDE JENISCH, of Philadelphia, to Francis Schumann, M.D., son of Dr. and Mrs. Edward A. Schumann, of Chalfont, July 1, in Germany.

MRS. BERT MARTIN HILBERTS, of Merion, to Willis Cadwallader Gerhart, M.D., son of Dr. and Mrs. Joseph M. Gerhart, Jr., of Cynwyd, June 22.

MISS MURIEL RANDOLPH SWANBURGH, of Philadelphia, to Mr. Floyd Charles Lepperd, Jr., son of Dr. and Mrs. Floyd C. Lepperd, of Hanover, July 1.

MISS SILVIA MARIE ROBERTS, daughter of Dr. and Mrs. Silvia J. Roberts, of Harrisburg, to Mr. Paul Edwin Herman, of Newberrytown, June 24.

MISS CHARLENE WILKENS, of Forest Hills, N. Y., to Mr. Robert Devers Hursh, son of Dr. and Mrs. Alexander M. W. Hursh, of Philadelphia, July 15.

MISS ELIZABETH C. MENCKE, daughter of the late Dr. and Mrs. J. Bernhard Mencke, of Philadelphia, to Mr. Richer M. Goodwin, also of Philadelphia, June 24.

MISS MARY ANN HARRISON FITZ-HUGH, daughter of Thomas Fitz-Hugh, Jr., M.D., of Wynnewood, and the late Mrs. Fitz-Hugh, to Mr. Dean Tolle Mace, of New York, June 24.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

Henry C. Bazett, Haverford; University of Oxford School of Medicine, England, 1920; aged 65; died aboard the liner *Queen Mary*, July 11, 1950, en route to the International Physiology Conference at Copenhagen, Denmark, where he had been scheduled to speak. Dr. Bazett, who was born in England, was professor of physiology at the University of Pennsylvania School of Medicine. He came to the university in 1921. He served with the British Army from 1914 to 1918, and was with the Royal Army Medical Corps and later with the medical section of the RAF. He retired from the Reserves with the rank of major in 1935. In 1944, Dr. Bazett became a consultant to the Military Planning Division, Office of Quartermaster General. He later became a member of the British Medical Research Council on Missions to India. He held many other appointments on commissions and investigative bodies in later years and was decorated several times. Dr. Bazett was a member of the Royal College of Surgeons, the College of Physicians of Philadelphia, the Physiological Society of America, and the Canadian Physiological So-

ciety. He is survived by his widow, a son, and a daughter.

○ **Frederick C. Lechner**, Montoursville; Jefferson Medical College of Philadelphia, 1919; aged 60; died July 21, 1950. He had been in ill health for almost two years and retired from active practice last July. Dr. Lechner was conspicuously active in the affairs of the Williamsport Hospital and in Montoursville educational matters. He became a member of the hospital staff in 1922, served as its president in 1938-39, and was one of the chiefs in the medical section. Prior to studying medicine, Dr. Lechner had taught school for ten years. Until a year ago, when he declined re-election, he was president of the borough school board for 11 years. He also served as president of the Lycoming County Medical Society. Surviving are his widow, a son, Capt. Frederick C., Jr., who is an Army physician, a daughter, who is a fourth-year student at Cornell University's Medical School, and a sister.

○ **George B. Moreland**, Pittsburgh; Hahnemann Medical College and Hospital of Philadelphia, 1893; aged 80; died July 7, 1950, in Shadyside Hospital, where he served as staff physician for almost 50 years. He entered the hospital June 18, suffering from a heart attack. He was president of the medical staff at Shadyside from 1927 to 1932, and was dean of the school of nursing from 1922 to 1939. The Moreland Room in the hospital's nurses' residence was built and furnished in his honor. A past president of the county and state societies of the American Institute of Homeopathy, Dr. Moreland was also a member of the Osteopathic Surgeons' Examining Board of Pennsylvania and a Fellow of the American College of Surgeons. During World War I, he served overseas as a captain in the U. S. Army Medical Corps. He is survived by two sons, a sister, and a brother.

○ **Sylvester S. Hamilton**, Punxsutawney; Medical College of Virginia, Richmond, 1931; aged 50; died July 6, 1950, following an operation in Pittsburgh. Dr. Hamilton specialized in cardiology and was on the staff of Adrian Hospital. Before studying medicine, he was graduated from the Philadelphia College of Pharmacy in 1921 and was employed as a pharmacist for several years. He was the son of one of Jefferson County's oldest practicing physicians, Dr. S. S. Hamilton, who died in 1939. He served with the U. S. Marines during World War I. Surviving are his widow, a son, and a sister, Mrs. Wilbur Gilmore, Evanston, Ill., who is also a physician.

○ **Myrtle R. Feltwell**, Imperial; University of Pittsburgh School of Medicine, 1904; aged 71; died June 16, 1950. Being afflicted all her life with infantile paralysis, and general practice being too strenuous, she took postgraduate work in pathology at Johns Hopkins Hospital, Baltimore, Md. From 1914 to 1927 she was pathologist at Presbyterian Hospital, Pittsburgh, and on a part-time basis at Sewickley Valley Hospital. From 1927 until her retirement in 1940, she served as resident pathologist at Sewickley Valley Hospital. A sister and a brother survive.

○ **George R. Good**, Williamsburg; University of Pennsylvania School of Medicine, 1933; aged 41; died

July 21, 1950. Dr. Good suffered from a heart condition and was ill for about two years, during which time he maintained his interest in county and state medical society affairs. He was secretary-treasurer of the Blair County Medical Society from 1943 to 1950 inclusive, and a member of the State Society's Commission on Public Health and Preventive Medicine. Surviving are his widow, one son, and two daughters.

○ **Arthur V. Donaldson**, Canonsburg; University of Pittsburgh School of Medicine, 1911; aged 65; died June 17, 1950, after a two weeks' illness. During World War II, Dr. Donaldson served as a medical inspector at Indiantown Gap from 1941 until 1946 and held the rank of lieutenant colonel. He was physician to the Pennsylvania Training School at Morgantown and was also a school physician. His survivors are his widow, a son, a daughter, a brother, and three sisters.

○ **Charles F. Kutscher**, Pittsburgh; University of Pittsburgh School of Medicine, 1927; aged 50; died June 3, 1950. Dr. Kutscher was associate professor of ophthalmology at the University of Pittsburgh. He was a member of the American Academy of Ophthalmology and Otolaryngology and the American Association of Industrial Physicians and Surgeons.

○ **John W. Lyons**, Jessup; Medico-Chirurgical College of Philadelphia, 1911; aged 65; died at his home July 30, 1950, following an illness of several months. Dr. Lyons was surgeon for several coal companies. He is survived by a son, John W. Lyons, Jr., who is a practicing physician in Philadelphia, a daughter, and a sister.

○ **Samuel J. S. Fife**, Bridgeville; University of Pittsburgh School of Medicine, 1893; aged 80; died July 18, 1950. He was the son of the late Dr. John Fife, of Clifton, and their combined services almost spanned a century. Surviving are one son, a grandson, and two sisters.

○ **William Tomlinson**, Seaford, Del.; Medico-Chirurgical College of Philadelphia, 1902; aged 80; died May 31, 1950. Dr. Tomlinson was retired. He was a member of the Allegheny County Medical Society in Pennsylvania.

○ **Chauncey A. Mintz**, Oil City; University of Pittsburgh School of Medicine, 1894; aged 80; died July 6, 1950. He was not in practice. His widow and a sister survive.

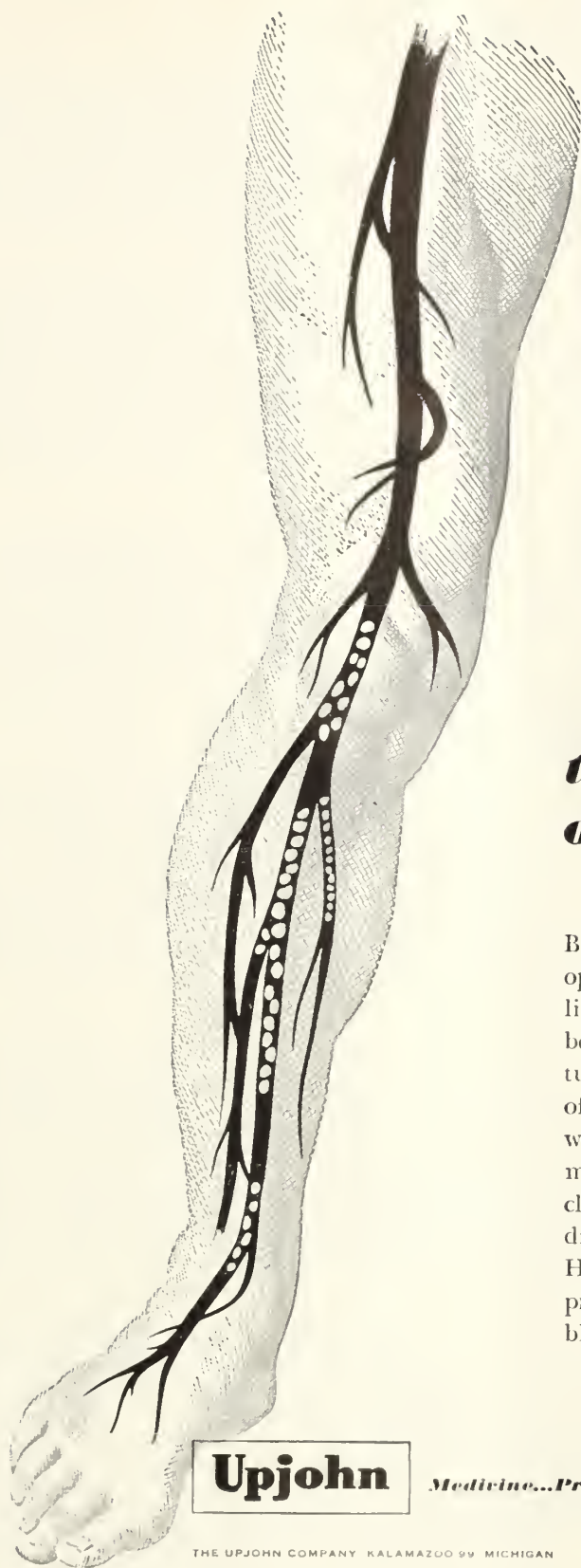
○ **Samuel W. Perry**, New Castle; Jefferson Medical College of Philadelphia, 1899; aged 76; died May 9, 1950. He was a Fellow of the American College of Physicians.

○ **David H. Edwards**, Washington; Eclectic Medical College, Cincinnati, Ohio, 1903; aged 70; died April 27, 1950.

Miscellaneous

DRS. C. HOWARD MARCY AND W. RODERICK BROWN, of Pittsburgh, have been elected to the board of directors of the National Tuberculosis Association.

SAVERIO F. BRUNETTI, M.D., has been appointed chief surgeon and Charles H. J. Barnett, M.D., assistant chief surgeon, in the Department of Public Safety, Philadelphia.



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Both morbidity and mortality from post-operative venous thrombosis and embolism, frequent sequelae to surgery, have been dramatically reduced by early institution of anticoagulant therapy. Studies of anticoagulants by Upjohn research workers have led to the development of many Heparin Sodium preparations, including long-acting Depo*-Heparin Sodium, with or without vasoconstrictors. Heparin Sodium preparations provide promptly effective and readily controllable anticoagulant therapy.

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MR. HARRY R. POOL, assistant manager of the Veterans Administration Center in St. Paul, Minn., has been appointed manager of the new V-A hospital in Wilkes-Barre, Pa., now nearing completion. The 475-bed hospital is expected to admit its first patients late this year.

THE THIRD ANNUAL CLINICAL CONFERENCE of the Wills Eye Hospital, Philadelphia, will be held at the hospital March 16 and 17, 1951. Papers which reveal the latest developments in ophthalmic treatment and procedures will be presented by many of the Nation's outstanding ophthalmologists.

THE EPISCOPAL HOSPITAL, Philadelphia, has been awarded a \$69,566 trust fund from which the Kensington Hospital for Women received the income prior to its closing nearly five years ago. The fund was established under the will of Miss Mary A. Dobbins as a memorial to her brother, who died in 1906.

JOHN E. DAVIS, JR., M.D., of Washington, D. C., has been appointed medical director of the new Eastern Psychiatric Institute at Philadelphia. When completed, it will complement a similar institution in western Pennsylvania—the Western Psychiatric Institute of Pittsburgh, which was opened in 1942.

THE VETERANS ADMINISTRATION has announced the appointment of James S. Grotfelty, M.D., chief of neuropsychiatry for eight midwestern and southwestern states, as manager of the V-A hospital at Lebanon. He

succeeds Dr. William J. McCarty, who has been named manager of the V-A hospital under construction at Poplar Bluff, Missouri.

DR. JAMES A. HARRISON, professor of biology at Temple University, has received a \$9,000 research grant-in-aid from the National Institutes of Health, U. S. Public Health Service. The grant will be used by Dr. Harrison to study the effects of various serums upon *Salmonella*, single-celled bacteria responsible for certain types of food poisoning and other serious infections.

THE VETERANS ADMINISTRATION has announced that Harrison S. Collisi, M.D., has been appointed manager and chief of professional services of the new V-A hospital in Erie. Dr. Collisi, a graduate of the University of Michigan Medical School in 1912, left the private practice of medicine in 1942 to enter the Army Medical Corps. He is being transferred to Erie from the Cleveland V-A hospital.

THE MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION will hold its sixth congress in Philadelphia, September 10 to 16, at the Woman's Medical College of Pennsylvania. Ninety-five women medical delegates from fifteen foreign countries are expected to attend. Dr. A. Charlotte Ruys, of Amsterdam, is the president of this association, and Dr. Ada Chree Reid, of New York City, is the president-elect.

THE INTERNATIONAL COLLEGE OF SURGEONS, United States Chapter, will hold its fifteenth annual assembly and convocation in Cleveland, Ohio, October 31 to November 3. The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose, and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic, and neurologic surgery. A program can be obtained by writing to Arnold S. Jackson, M.D., Secretary, Jackson Clinic, Madison 4, Wis.

THE THIRD ANNUAL SYMPOSIUM ON ORTHOPEDIC APPLIANCES will be held at the Mellon Institute, Pittsburgh, during the week of September 18. This symposium will again be a cooperative undertaking of the Department of Orthopedic Surgery of the University of Pittsburgh's School of Medicine and the Sarah Mellon Scaife Foundation's multiple fellowship on orthopedic appliances at Mellon Institute. Further information may be secured by writing to Dr. E. R. Weidlein, director of Mellon Institute, Pittsburgh 13.

ON SEPTEMBER 21, 22, AND 23 the Frank E. Bunts Institute and the Cleveland Clinic will present a continuation course for physicians on "Practical Problems in General Medicine." Dr. M. A. Blankenhorn, professor of medicine at the University of Cincinnati, will give the evening address, September 21, on "The Rickettsial Diseases." The other out-of-town guest speakers will be Dr. D. W. Pickering, who is director of the medical unit at St. Mary's Hospital, London, England, and Dr. E. Braun-Menendez of Buenos Aires, Argentina, who will speak on "Pathogenic Basis of the

Postgraduate Course

AT

HAHNEMANN HOSPITAL

Another postgraduate course in Cardiology will be given during the coming winter. Starting in October, on Thursday afternoons from 2:00 to 5:00, thirty sessions will be held. Modern diagnosis and treatment of various forms of heart disease will be discussed. Registration is limited and individual instruction will be emphasized.

Detailed information will be forwarded upon request to Dr. George D. Geckeler, Hahnemann Hospital, Philadelphia 2. Early registration is suggested.

Treatment of Hypertension." Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third St., Cleveland 6, Ohio.

DONALD GUTHRIE, M.D., surgeon-in-chief of the Guthrie Clinic and Robert Packer Hospital, Sayre, has been appointed professor of clinical surgery at the Graduate School of Medicine of the University of Pennsylvania. Dr. Guthrie has served for 13 years as associate professor of surgery at the Graduate School.

The Guthrie Clinic and Robert Packer Hospital have been associated with the Graduate School of Medicine of the University of Pennsylvania for the training of men in the specialty of surgery. In addition to general surgery, the Guthrie Clinic accepts Fellows in urology, orthopedic surgery, and internal medicine. These men may qualify for the degree of Master of Medical Science for original work performed while serving their fellowships at the Guthrie Clinic and Robert Packer Hospital.

THE ARTHRITIS AND RHEUMATISM FOUNDATION is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from \$4,000 to \$6,000, depending upon the needs and ability of the worker, and run for a period of one year. The fellowships are to begin in July, 1951, although earlier appointments would be considered by the committee.

The Foundation is anxious to back a candidate rather than a project, an institution, or a hospital. It hopes to arouse interest in arthritis in a wider circle of medical investigators and to encourage able, inquiring minds.

Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Ave., New York 17, N. Y., by Jan. 1, 1951. Notification of the fellowships granted will be made March 1, 1951.

If any applications are received by Sept. 15, 1950, they will be acted on at that time and notification made immediately.

AT THE DECEMBER, 1949, INTERIM SESSION OF THE AMA HOUSE OF DELEGATES a resolution was passed requiring the AMA Board of Trustees to appoint a Coordinating Committee on Legislation to consist of not less than seven members from the trustees and general membership.

"The committee's function should be the facilitating of the activities on legislative matters and the dissemination and distribution of legislative information throughout the various states."

The following were appointed:

Dwight H. Murray, chairman, Napa, Calif.
Oscar B. Hunter, vice-chairman, Washington, D. C.
Joseph D. McCarthy, Omaha, Neb.
F. J. L. Blasingame, Wharton, Tex.
M. J. Dattelbaum, Brooklyn, N. Y.
Willis H. Huron, Iron Mountain, Mich.
Deering G. Smith, Nashua, N. H.
Julian P. Price, Florence, S. C.
McKinnie L. Phelps, Denver, Colo.
and ex officio

Edwin S. Hamilton, Kankakee, Ill.
Gunnar Gundersen, La Crosse, Wis.
Walter B. Martin, Norfolk, Va.

Since this action, the Board of Trustees of the AMA has changed the name of the committee to simply the *Committee on Legislation*, which functions under the Board of Trustees.

On request of Chairman Murray, Dr. C. L. Pahner, chairman of the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania, was appointed to this committee.

Serious problems of pregnancy made crystal-clear:
To the practitioner who supervises 50 or 500 pregnancies annually, the paper beginning on page 817 of this issue should prove extremely helpful.

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For Sale.—Late model Jones metabolism machine. Used one time. Reasonable. Write J. EDWARD BOOK, M.D., Newport, Pa.

For Sale.—Instruments, books, and office equipment of recently deceased physician who did general practice and eye, ear, nose and throat work. Write Mrs. L. N. REICHLARD, 306 Front St., Brownsville, Pa.

Wanted.—Physician licensed in Pennsylvania qualified to take over as Director of Anesthesiology in approved general hospital in Pittsburgh. Salary open. Write Dept. 212, PENNSYLVANIA MEDICAL JOURNAL.

For Rent.—Completely equipped office with active general practice. To be rented with privilege of buying after one year. Small community in northeastern Pennsylvania. Only doctor. Hospital facilities. Write Dept. 216, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Pathologist, diplomate or qualified for board examinations, to associate with and succeed present director who is retiring soon. Modern, approved, 200-bed hospital. Write WASHINGTON HOSPITAL, Washington, Pa.

Wanted Immediately.—Two house physicians for a 200-bed general hospital. Approved by the American College of Surgeons. These residencies offer a wealth of experience, good salary, and full maintenance. Apply SUPERINTENDENT, INDIANA HOSPITAL, Indiana, Pa.

Wanted.—Young doctor, Pennsylvania license, to assist in office Oct. 1, 1950 through Dec. 31, 1950 while partner is doing graduate work. Western Pennsylvania town of 4500. Write Dept. 210, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Physicians in eastern Pennsylvania state mental institution which is accredited by American Board of Neurology and Psychiatry. Pennsylvania license necessary. Housing available. Write Dept. 215, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Doctor's residence with fully equipped offices at 612 West Market St., Pottsville, Pa. For sale because of death. Well-established ophthalmologic practice. Excellent opportunity. Write Mr. F. C. MENGEL, 38 St. John St., Schuylkill Haven, Pa.

Wanted.—General practitioner for community near Washington, Pennsylvania. Office, equipment, housing made available. Offers attractive future. Willing to discuss yearly guarantee. Write Mr. WILLIS L. KENNEDY, Washington and Jefferson College, Washington, Pa.

For Sale.—Modern fully equipped eight room office with established general practice in south central Pennsylvania town of 18,000, with new \$2,000,000 hospital. Price of equipment only, terms. Large apartment available. Specializing. Write Dept. 214, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Combination home and office. Small town in eastern Pennsylvania. Some industrial work with salary. Other contacts available. Immediate possession. Good reason for selling. Excellent opportunity for young man. Price reasonable. Write Dept. 209, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—General practice with all supplies and equipment for price of equipment alone; includes 100 KV, 100 MA x-ray and fluoroscopic unit with all accessories. Office suite of six rooms in central location of small industrial community 30 miles west of Philadelphia. Price, \$5,000. Write Dept. 183, PENNSYLVANIA MEDICAL JOURNAL.

Wanted at Once.—Physician with Pennsylvania license for general and industrial bituminous mining practice. Near general hospital. Salary \$800 to \$1,500 a month. No investment needed. House available. Desirable community. Contact F. J. KELLAM, M.D., Indiana, Pa., Telephone—Indiana 374. (50 miles north of Pittsburgh.)

Opportunities for Physicians.—Are you interested in a position in one of our county or district health departments? Salary \$5,600 to \$7,200 with \$70 a month travel allowance. Public health scholarships available with liberal stipends. Men and women physicians eligible. Write FELIX J. UNDERWOOD, M.D., Mississippi State Board of Health, Jackson, Miss.

Wanted.—General practitioner for assistant to well-established and older Fellow of the American College of Surgeons. Married man desired. Good hospital facilities. Salary for first six months, then percentage. Apartment available in suburban area of twin cities. Great future. Minnesota license or national boards necessary. Write Dept. 207, PENNSYLVANIA MEDICAL JOURNAL.

Locum Tenens.—Choice general practice ("Office hours—By Appointment Only" type) with active records on approximately 5300 patients open September 20, 1950 to June 1, 1951, in northwestern Pennsylvania community of 60,000 people. Fully equipped office suite of six rooms. Ideal financial set-up for doctor awaiting 1951 residency. Write Dept. 213, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Staff physician for 105-bed private tuberculosis sanatorium, central Pennsylvania. Medical and surgical phases covered, including bronchoscopy; outpatient service. Excellent opportunity to learn. Pennsylvania license or reciprocity required. House and maintenance for physician and family; congenial surroundings. Inquire MEDICAL DIRECTOR or SUPERINTENDENT, Devitt's Camp, Allenwood, Pa.

Wanted.—General practitioner for town of McAlisterville. Located in Juniata County in agriculture and hatching section. Population of 600 with surrounding area including approximately 3000 persons. Civic leaders very interested in securing physician. New house available. For further information contact Mr. WAYNE W. GOODLING, McAlisterville Shoe Store, McAlisterville, Pa.

Mixed Residencies.—Available immediately; rotating service with special emphasis on obstetrics, surgery, medicine, contagion, pediatrics. Adjacent to large teaching centers, excellent opportunity for men interested in entering general practice. Complete teaching program. Large emergency accident service. Salary \$250 per month plus full maintenance for individual. Apply DIRECTOR, WILMINGTON GENERAL HOSPITAL, Wilmington, Delaware.

Part-time Physician Wanted.—Two hydro-electric companies having plants within twenty miles of Lancaster desire part-time services of young physician for employees and their families residing in or near companies' villages. Modern office and other equipment provided. Residence available in company village at reasonable rental. Private practice available in village and surrounding areas. Physician entitled to pension, hospitalization, life insurance, sick benefit, and vacation with pay. Address replies to Mr. J. U. DIEHL, P. O. Box 2076, Baltimore 3, Md., stating salary desired, age, education (including postgraduate training), experience, and date available.

BOOK REVIEWS

Clinical Pathology. Application and Interpretation. By Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock, Ark. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$6.00.

Dr. Wells has recorded in a pleasing fashion a general appraisal of the contribution the laboratory may make to the physician in the process of investigating daily medical and surgical problems, along with some of the more infrequently encountered entities. This discourse advises as to when a particular laboratory test should be used, how to interpret the results, and the technical or physiologic limitations of this interpretation. Technical details have been omitted, as have references to the various procedures. Exception to this is the inclusion of references to accepted procedures in the appendix where tables of normals are provided.

The infectious diseases, diseases of the gastro-intestinal system, respiratory system, kidney and urinary tract, blood, cardiovascular, metabolic, and endocrine disorders, and studies in surgery and obstetrics are discussed. Of particular note is the excellent review of the laboratory aids in evaluating hematologic problems. It assists in minimizing the mystery attached to the complex terminology and confusion in this field which correctly is attributed to the intricacies of the experimental and developmental phases of hematology.

This book is recommended to every physician who requires assistance in diagnosis from the laboratory. It provides a perspective of the contribution that the average small or large laboratory may make to the average daily patient problem.

The Cerebral Cortex of Man. A Clinical Study of Localization of Function. By Wilder Penfield, M.D., and Theodore Rasmussen, M.D. New York: The Macmillan Company, 1950. Price, \$6.50.

The review of a scientific work of this magnitude in a journal intended for the general profession presents a great deal of difficulty. Not only does it present a great task to the average reader, because of the technical knowledge in basic neuro-anatomy and neuropathology that is required, but it also presupposes a profound knowledge of the modern literature of experimental work in localization. The reluctance of the general practitioner to touch anything neurologic is well known, and it is the problem of harmonizing these two opposites and how to interest the physician with-

out frightening him away altogether that makes it the forbidding task that it is.

And yet, the information contained in this work is badly needed by the medical man. Drs. Penfield and Rasmussen present a magnificent piece of work which took many years of study, and painstaking application of their method of research in the operating room especially, in order to throw light on the function of the cerebral cortex. Careful protocols have been kept and the whole presents a great step forward in our understanding of the functions of the human brain.

The authors aptly pave the way for the need of this kind of work by the following statement in their "Historical Note": "Scientists have studied these neural mechanisms, and they will continue to do so generation after generation, until at last a comprehensive understanding, a science, will emerge."

The method consisted of studying brain-surgical cases in the operating room under local anesthesia and using cortical stimulation. The authors speak of "electrocorticograms." The designation of the various cortical areas, their delineation and type of function represented, depends on the responses elicited from the patients themselves. The authors took precaution to establish these findings on a sound basis. Thus, they say: "In reviewing these records, any movement or sensation which is part of an epileptiform seizure produced by the stimulation is disregarded from an anatomical point of view; those responses which are not verified upon repeating the stimulation are likewise not included in the analysis of the records."

Comprehensive studies were made on cerebral functions. Chapters are devoted to sensorimotor representation of the body, head and eye movement, vision, vocalization, etc. Extremely fascinating is the investigation of the temporal lobe dealing with "Memory, Sensory Perception, and Dreams." One must study this carefully to appreciate the excellency of the work.

The illustrations are unusually good, easy to follow, and very illuminating. The authors are unduly modest in their estimation of their own work. They say: "But it is impossible for us to attempt a final conclusion regarding the physiology of the cerebral cortex of man. The writing of this report has served the most useful purpose of analysis, and has made possible comparison with the findings of others. Some facts which were only suspected are now substantiated. Some hypotheses still lack adequate proof."

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While the book is admittedly rather difficult for the average general practitioner, it is a "must" for the neuropsychiatrist and the internist, and it is worth the effort of the general practitioner who wants to keep abreast of medical progress. One's labors in studying this book are sure to be rewarded by a sense of inner satisfaction upon the acquisition of basic and essential knowledge.

A Monograph on Sucking Habits (Thumb, Finger, and Hand Sucking). By Paul J. Mandabach, Sr.

The author has made an extensive survey of medical, dental, and consumer literature on thumb sucking, following which he published a monograph in the hope that children will not be faced with the ordeal of malocclusion. Copies may be obtained free of charge by writing the author at 677 N. Michigan Ave., Chicago 11, Ill.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Elements of Medical Mycology. By Jacob Hyams Swartz, M.D., Assistant Professor of Dermatology, Harvard Medical School and Postgraduate School; Member of American Dermatological Association and American Mycological Association; Diplomate of American Board of Dermatology; Dermatologist to Massachusetts General Hospital. In collaboration with Ethel M. Rockwood, M.D., Dermatologist to Massachusetts General Hospital. Introduction by Fred D. Weidman, M.D., Professor of Dermatological Research, University of Pennsylvania. Second edition. New York: Grune & Stratton, 1949. Price, \$5.50.

The Practice of Medicine. By Jonathan Campbell Meakins, C.B.E., M.D., LL.D., D.Sc., formerly Professor of Medicine and Director of the Department of Medicine, McGill University; formerly Physician-in-Chief, Royal Victoria Hospital, Montreal; formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Fellow of the Royal Society of Edinburgh, the Royal Society of Canada, the Royal College of Physicians, London, the Royal College of Physicians, Edinburgh, the Royal College of Physicians, Canada, and the American College of Physicians; Honorary Fellow of the Royal College of Surgeons, Edinburgh, and the Royal Society of Medicine. Fifth edition. With 517 illustrations including 50 in color. St. Louis: The C. V. Mosby Company, 1950. Price, \$13.50.

Studies in Lobotomy. By Milton Greenblatt, M.D., Robert Arnot, M.D., and Harry C. Solomon, M.D. New York: Grune & Stratton, Inc., 1950. Price, \$10.00.

Modern Practice in Dermatology. Edited by G. B. Mitchell-Heggs, O.B.E., M.D., F.R.C.P., Physician-in-charge, Skin Department, St. Mary's Hospital and Medical School, London; Physician to St. John's Hos-

pital for Diseases of the Skin and Institute of Dermatology, University of London; Member of Advisory Panel on Dermatitis, Ministry of Labour and National Service. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1950. Price, \$12.50.

The Mask of Sanity. An attempt to clarify some issues about the so-called psychopathic personality. By Harvey Cleckley, M.D., Professor of Psychiatry and Neurology, University of Georgia School of Medicine, Augusta, Ga. Second edition. St. Louis: The C. V. Mosby Company, 1950. Price, \$6.50.

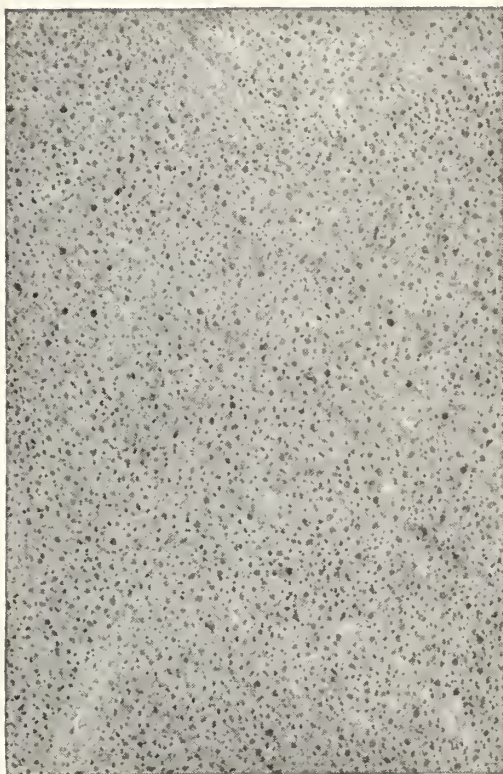
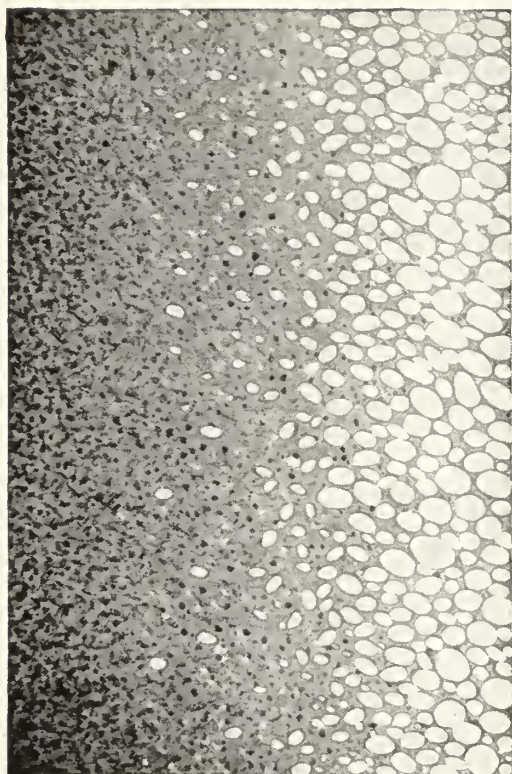
Maternity Care in Two Counties (Gibson County, Tennessee, and Pike County, Mississippi, 1940-41, 1943-44). By Frank E. Whitacre, M.D., Chief of Division of Gynecology and Obstetrics, University of Tennessee College of Medicine, and Ellen Whiteman Jones, M.P.H., Statistician for The Commonwealth Fund. New York: The Commonwealth Fund, 1950.

Handbook of Physiology and Biochemistry. Originally "Kirkes'" and later "Halliburton's." By R. J. S. McDowall, M.D., D.Sc., Professor of Physiology, University of London, King's College. Centenary edition. London: John Murray, Albemarle Street. Philadelphia: The Blakiston Company, 1950. Price, \$7.00.

BLOOD BANKS AND BULLETIN 75

The Bureau of Medical Economic Research of the American Medical Association, conducting a survey of blood banks in the United States and possessions, recently issued Bulletin No. 75 dealing with blood banks, which the Bulletin defines as "an institution which stores blood whether or not it also procures or processes blood." Bulletin 75 has been distributed, among others, to secretaries of state and county medical societies throughout the Nation.

The most recent communication from this AMA Bureau, received August 2, seeks the assistance of medical society secretaries in obtaining additional data about blood banks in Pennsylvania. Bulletin No. 75 lists hospital and non-hospital blood banks in Pennsylvania. This list should be reviewed locally by each county society secretary and, if he has knowledge that a blood bank located in his county has not been included, he should add this information to the Special Blood Bank Questionnaire now in his possession, and having completed said questionnaire return it promptly to 535 N. Dearborn St., Chicago 10, Ill.



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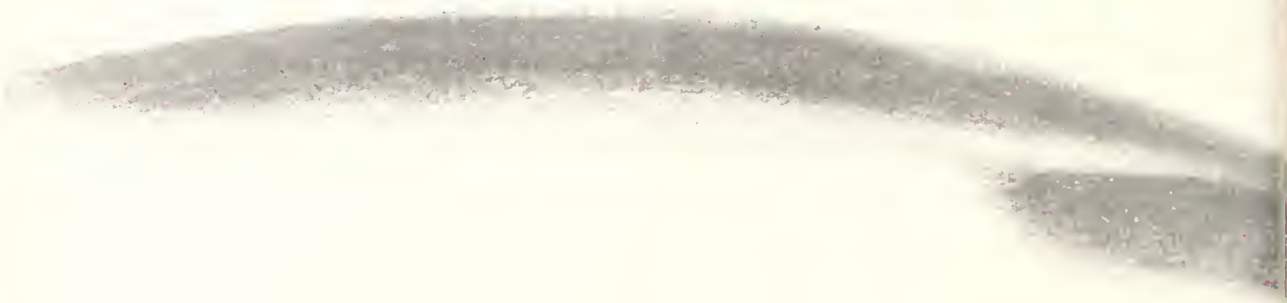
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An Editorial

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Carbon	Marvin Evans, Lansford	John L. Bond, Lehighton	Bimonthly
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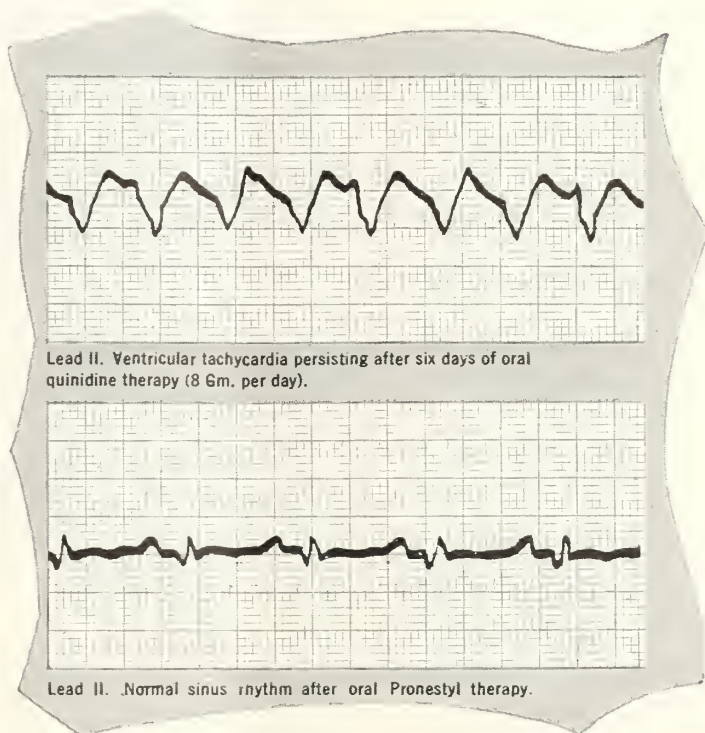
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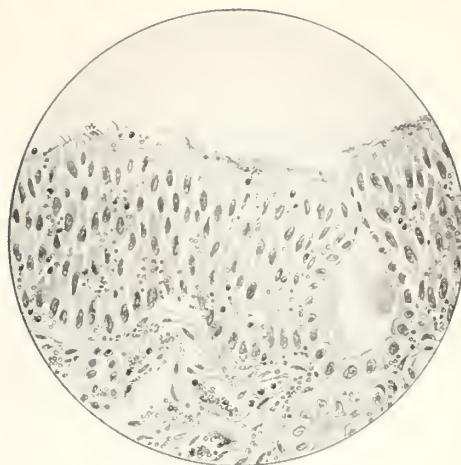
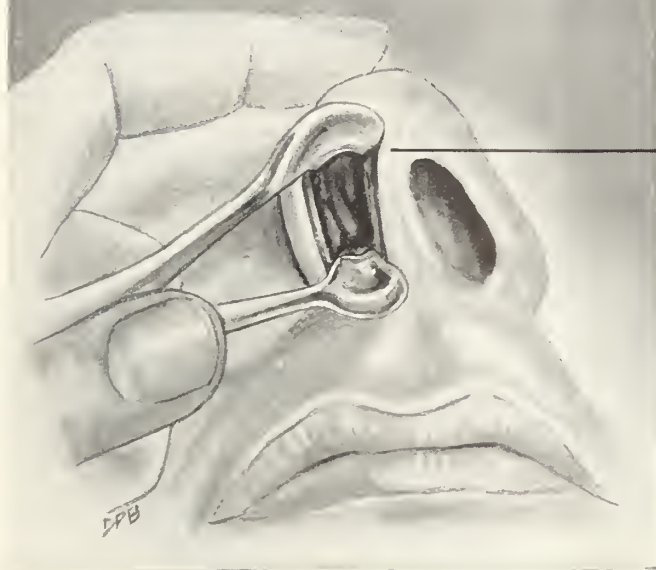
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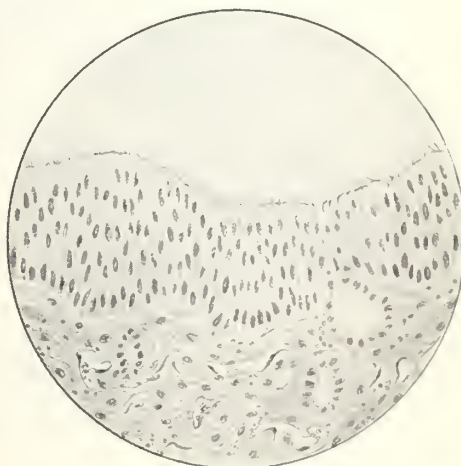
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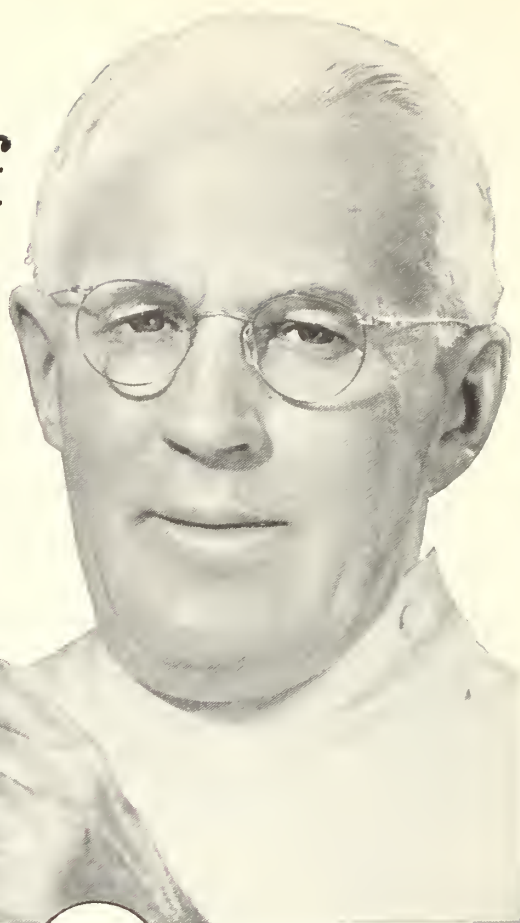
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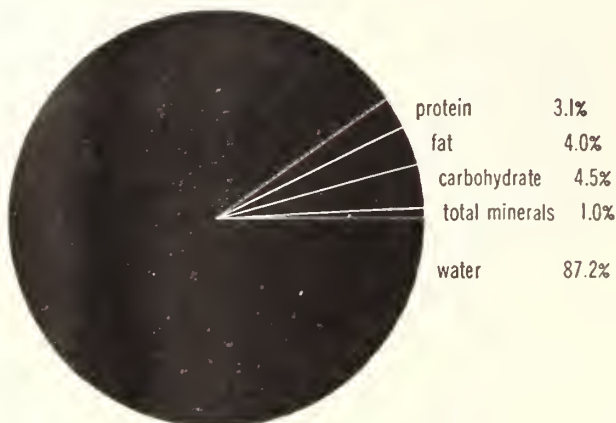
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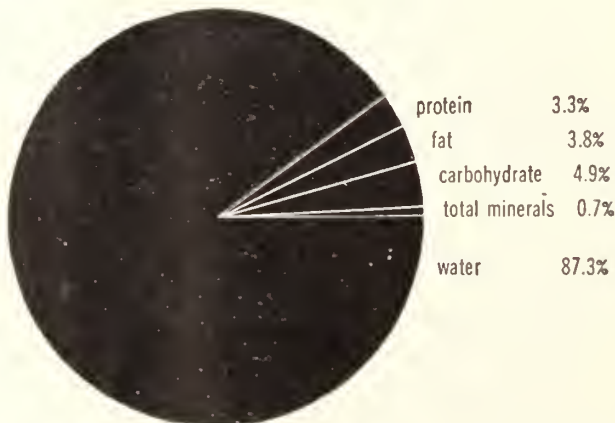


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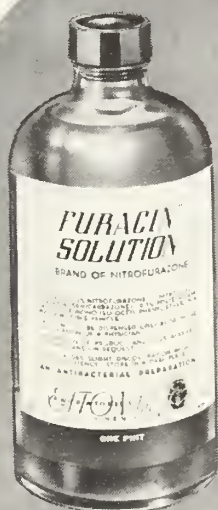
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Clinical Experience with Mercurital, an Oral Mercurial Diuretic, in Ambulatory Patients

WILLIAM D. STROUD, M.D., LOUIS B. LAPLACE, M.D.,
JOSEPH A. WAGNER, M.D., and IRA BEN MILLER, M.D.
Philadelphia, Pa.

ORAL administration of the mercurial diuretics has been reported to be useful in the treatment of certain types of edema. The oral route has obvious advantages over the prevalent method of parenteral administration. It eliminates injections and avoids sudden profuse diuresis which is often distressing to the patient and may seriously disturb fluid and electrolyte balance. Several oral preparations have already been introduced. There is, however a considerable difference of opinion regarding their relative effectiveness and limitations as compared with the parenteral route.² New preparations which claim superiority over those now available are therefore deserving of careful study. One of these is mercurital* and the present report is concerned with the results of its clinical trial in ambulatory patients.

Mercurital is a combination of mersalyl acid and theobromine calcium, the latter being marketed commercially under the trade name, purital. The mercurial component is similar to that of other mercurial diuretics. The principal characteristic of mercurital is the combination with

theobromine calcium. The fact that purital has appeared to be relatively well tolerated as compared with other xanthine preparations³ suggested that its use might be advantageous in a mercurial diuretic for oral administration. Mercurital is prepared in an uncoated tablet containing approximately 60 mg. of mersalyl acid which is equivalent to 24 mg. of mercury.

Methods

The procedure of study consisted in the substitution of mercurital for parenteral injections of mercurial diuretics in ambulatory patients. The patients were currently under treatment in the cardiac clinics of the Pennsylvania Hospital and Jefferson Hospital; a few were private patients. The series included a total of 22 patients, of whom 15 were males and 7 females; their ages ranged from 18 to 71 years. All patients had existing or impending congestive failure due to advanced rheumatic, hypertensive, or arteriosclerotic heart disease. In each case one or two weekly injections of 1 to 2 cc. of a mercurial diuretic had been required to control the congestive manifestations.

The observations made regarding the effect of mercurital therapy were essentially the routine studies used in cases of congestive failure treated

From the Cardiac Clinics of the Pennsylvania and Jefferson Hospitals.

* Mercurital used in this study was generously supplied by the A. J. Parker Company, Philadelphia, Pa.

by parenteral diuretics. These included weekly or biweekly examinations with special attention to progression or regression of the manifestations of failure, evidence of untoward drug effect, and preference of the patient as to the type of medication. Laboratory studies, including blood counts, urinalyses, blood urea nitrogen determinations, and electrocardiograms, were made as indicated. All patients were observed during mercurital administration over a period of one to eight months.

Whenever practical, control studies were made to confirm the necessity for a mercurial diuretic and a placebo was substituted for the mercurital tablets. In each instance, the manifestations of congestive failure increased progressively and, if the test were allowed to continue, the patients required hospitalization.

Results

In all cases requiring one or two weekly injections of a mercurial diuretic, the manifestations of congestive failure were found to be equally well controlled by oral administration of mercurital. The incidence of recurrence of severe congestive failure requiring hospitalization was no higher than among patients taking parenteral diuretics. In no such instance did it appear likely that failure would have been prevented had the mercurial diuretic been taken parenterally once or twice a week.

The dosage of mercurital was found to average one to three tablets daily. As might be expected, the daily dosage required variation from time to time as the condition of the patient tended to change. Considering the patients as a group, therefore, rather than as individuals, the daily maintenance dose was two tablets in approximately half of the total patient days, one tablet in approximately 25 per cent, and three tablets in the remaining 25 per cent of the total patient days. Occasionally, a patient required four tablets daily but this dosage was never continued indefinitely without either sufficient improvement to permit a smaller dose or progressive failure which required confinement to bed or hospitalization.

All patients, except during the occurrence of certain untoward effects described below, stated that they preferred mercurital to receiving a diuretic by injection. Preference was based chiefly on the avoidance of profuse diuresis. There were no instances of the patient being awakened by nocturia due to the drug. None of the patients

noted any of the distressing symptoms which often accompany sudden marked loss of fluid. One patient stated at first that mercurital caused gastric discomfort and that he could not take any medication by mouth because of a "sensitive stomach"; later mercurital was again tried and this time there was no complaint. All patients were instructed to take the tablet with meals to minimize any tendency to nausea. Some patients nevertheless took them on an empty stomach, apparently without ill effect. No evidence of renal damage or impairment of function due to mercury was detected, nor were there any instances of acute reactions such as occasionally appear when the mercurial diuretics are given by injection.

Definite untoward effects of mercurital were of two types—abdominal cramps and diarrhea, and soreness of the gums. These conditions were often difficult to evaluate accurately in relation to the possible causal influence of the drug. Acute infectious enterocolitis was prevalent and was responsible for several episodes of abdominal pain and diarrhea which might easily have been mistaken for effects of mercury. When stomatitis occurred, peridental infection almost invariably appeared to be at least a contributory factor. There were no instances of it in patients who were completely edentulous and in most cases it could be adequately controlled if proper oral hygiene were practiced.

Of the entire group, stomatitis and/or some form of intestinal disorder occurred as complications definitely attributable to mercury in six patients. They developed during the period of two weeks to two months after beginning mercurital administration. When the drug was withdrawn and later resumed, they tended to recur sooner than at first. They occurred only when the dosage was two or more tablets daily. They were usually mild, the cramps disappearing promptly on withdrawal of the drug and the soreness of the gums requiring somewhat longer, one to three weeks as a rule. Half of the patients in whom these complications developed were able to resume mercurital administration later in smaller dosage, especially if the drug was temporarily withheld for a few days every two to four weeks and adequate oral hygiene was practiced.

Illustrative Cases

CASE 1.—D. H., a 44-year-old man who has rheumatic heart disease with huge cardiac enlargement, aortic insufficiency, mitral stenosis, auricular fibrillation, and chronic congestive failure, had received digitalis and

weekly 2 cc. intravenous injections of a mercurial diuretic for three years. His weight for three months preceding mercurial therapy averaged 155 to 165 pounds. On Nov. 15, 1949, the intravenous diuretic was replaced by mercurital, two tablets daily. His weight for the next six weeks averaged 156 to 162 pounds. He stated that he preferred mercurital and felt better while taking it, but after five weeks he began to complain of sore gums. The following week, a placebo was substituted for the mercurital. The edema increased steadily and a month later he required hospitalization for severe failure with a weight gain of 18 pounds. On discharge, mercurital therapy was resumed and the congestive failure was controlled by four tablets daily. Two weeks later, however, the gums again became sore and after a month mercurital had to be replaced by an intravenous mercurial. On July 7 mercurital was resumed, but this time the gums became sore within a week and the drug was permanently discontinued.

CASE 2.—C. B., a 31-year-old woman who has rheumatic heart disease with moderate cardiac enlargement, mitral stenosis and insufficiency, auricular fibrillation, and chronic congestive failure, had received digitalis and weekly 2 cc. intravenous injections of a mercurial diuretic for one year. Her weight for three months preceding mercurital therapy averaged 118 to 133 pounds. On Nov. 1, 1949, following discharge from the hospital, the intravenous diuretic was replaced by mercurital, two tablets daily. The patient's condition remained unchanged until the following month when mercurital was discontinued and hospitalization was required for congestive failure. On Jan. 3, 1950, the patient resumed mercurital therapy, three tablets daily, which was later decreased to one tablet daily and continued in this dosage. By Aug. 1, 1950, there had been no recurrence of congestive failure and the weight had averaged 111 to 122 pounds. The patient at no time had any untoward effect from mercurital and greatly prefers it to intravenous mercurial therapy.

CASE 3.—J. K., a 63-year-old man who has arteriosclerotic heart disease with moderate cardiac enlargement, aortic stenosis and insufficiency, auricular fibrillation, and congestive heart failure, had received digitalis and weekly 2 cc. intravenous injections of a mercurial diuretic for two years. His weight for three months preceding mercurital therapy averaged 135 to 145 pounds. On Nov. 7, 1949, the intravenous diuretic was replaced by mercurital, two tablets daily. On two occasions subsequently, a placebo was substituted for mercurital and each time the weight increased 5 pounds in a week with aggravation of the manifestations of failure. Otherwise, the weight averaged 132 to 141 pounds and the congestive failure was well controlled by mercurital in dosage of two to three tablets daily, which was still being taken on Aug. 1, 1950. There were no untoward effects of any type and the patient prefers mercurital because of avoidance of the injections and of the nocturia which they caused him.

CASE 4.—M. L., a 53-year-old woman who has thyrotoxic and rheumatic heart disease with moderate cardiac enlargement, mitral insufficiency, auricular fibrillation, and chronic congestive failure, had received weekly 2 cc. intravenous injections of a mercurial di-

uretic for three years. Digitalis had been given occasionally but was poorly tolerated. The patient's weight for three months preceding mercurital therapy averaged 124 to 146 pounds. On Nov. 29, 1949, the intravenous diuretic was replaced by mercurital, two tablets daily. Two weeks later, the patient complained of abdominal cramps and the dose was reduced to one tablet daily, but with subsiding of the cramps the previous dose was resumed on the following week. On Jan. 3, 1950, a placebo was substituted for the mercurital and in three weeks the weight had increased 8 pounds and congestive failure had become very distressing. Mercurital was resumed in dosage of two tablets daily, which was still being taken on Aug. 1, 1950. The congestive failure was well controlled and the weight averaged 132 to 146 pounds. There were no untoward effects of any type and the patient preferred mercurital to intravenous diuretics.

CASE 5.—J. D., a 67-year-old man, who has arteriosclerotic and hypertensive heart disease with marked cardiac enlargement, auricular fibrillation, and chronic congestive failure, had received digitalis and weekly 2 cc. intravenous injections of a mercurial diuretic for one year. His weight for three months preceding mercurital therapy averaged 166 to 176 pounds. On Nov. 15, 1949, the intravenous diuretic was replaced by mercurital, four tablets daily. His condition improved and by Jan. 24, 1950, he had lost 8 pounds in weight. Mercurital was then reduced to three tablets daily and for the next two months congestive failure was well controlled and the weight averaged 163 to 172 pounds. In April, 1950, treatment was discontinued due to domestic difficulties and the congestive failure became more manifest. On the patient's return to the clinic, an intravenous diuretic was given twice to hasten improvement, but from May to August, 1950, failure was well controlled and weight stabilized by three tablets of mercurital daily. There have been no untoward effects of therapy.

CASE 6.—A. R., a 26-year-old man who has rheumatic heart disease with huge cardiac enlargement, mitral stenosis and insufficiency, auricular fibrillation, and chronic congestive failure, had received digitalis and weekly 2 cc. intravenous injections of a mercurial diuretic for one year. His weight for three months preceding mercurital therapy averaged 136 to 142 pounds. On Nov. 1, 1949, the intravenous diuretic was replaced by mercurital, two tablets daily, which was increased on November 29 to three tablets daily. The patient's condition improved and his weight fell from 140 to 131 pounds. For two months he considered mercurital "wonderful," but on Jan. 10, 1950, he began to complain of sore gums, abdominal cramps, and diarrhea. A placebo was substituted for mercurital and in three weeks an increase in congestive failure necessitated his hospitalization. On March 14 mercurital was resumed in dosage of two tablets daily, but soreness of the gums recurred within three weeks and cramps within six weeks, so that mercurital was discontinued on April 25. The cramps subsided by the following week, but the sore gums persisted for two weeks. Since then, the patient has regretfully refused further mercurital therapy and has remained stabilized by weekly mercurial injections.

On the basis of the present study, it appears that mercurital is effective in controlling the manifestations of congestive heart failure in ambulatory patients who would otherwise require weekly parenteral administration of 1 to 2 cc. of a mercurial diuretic. In the average case of this type, mercurital appeared preferable to the parenterally administered preparations since it eliminated the need for injections and, more important, the often disturbing effects of profuse diuresis. The possibility of acute reactions to injection therapy is likewise avoided. Gastric irritation and nausea which commonly detract from the usefulness of oral mercurial diuretics are minimized.

Like other mercurial diuretics for oral administration, mercurital tends in certain patients to produce soreness of the gums and abdominal cramps and diarrhea. These complications appeared to be manifestations of chronic rather than acute mercurial toxicity. The fact that they occur when the drug is given by mouth rather than by injection suggests that they are probably due to the more constant exposure of the tissues to mercury. There appears, however, to be a definite individual predisposition to these complications. In regard to the occurrence of stomatitis, one factor is certainly the presence of chronic oral infection. The incidence of complications has appeared to vary in different patient groups, being greater at the lower economic levels.⁴ Untoward effects of mercurital depend largely, however, as in the case of other oral mercurial diuretics, on the care with which the drug is administered. The minimal effective dosage should be used, and when any evidence of untoward effect first appears, the drug should be discontinued for a few days at regular intervals to permit elimination of accumulated mercury.

1. Mercurital, an oral mercurial diuretic composed of mersalyl acid and theobromine calcium (purital), was administered for a period of one to eight months to a series of 22 ambulatory patients who previously required one or two weekly injections of a parenteral mercurial diuretic for the control of congestive heart failure.

2. Mercurital was found to be as effective as the parenteral preparations in the prevention and control of congestive failure in ambulatory patients when given in dosage of one to three tablets daily.

3. Although gastric irritation and nausea appeared to be minimized, mercurital, like other oral preparations, caused soreness of the gums and abdominal cramps and diarrhea in certain patients. These untoward effects occurred in six cases of the present series, all of whom were taking two or more tablets daily. They prohibited further use of the drug in four of these patients and the remainder were adequately controlled by temporary withdrawal of the drug, reduction of dosage, and improvement in oral hygiene.

4. The use of mercurital appears to be preferable to the parenteral administration of mercurial diuretics for ambulatory patients in the absence of individual susceptibility to complicating stomatitis and intestinal disorders.

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PRESIDENT'S RECEPTION AND DANCE

The annual President's Reception and Dance honoring the president and president-elect will be held Wednesday evening, October 18, at 9 p.m., in the ballroom of the Bellevue-Stratford Hotel. Formal dress is optional. Music will be furnished by Clarence Fuhrman's KYW Orchestra. Get your tickets now by using the order form on page 1008.

Progress Report on American Medicine

ERNEST E. IRONS, M.D.

Chicago, Ill.

PHYSICIANS of this nation are deeply concerned with the prevention of sickness and injury of all our fellow citizens. The care of the sick, the prevention of disease, and the alleviation of suffering are the center, the impelling motive, the inspiration, around which are built all the activities of the medical profession. The universally recognized accomplishments of medicine by the combined efforts of research and the application of new knowledge in careful and intelligent practice have been attained in a nation of free enterprise and, in the past, sound economy. The problems of medicine are closely integrated with the economic and social conditions of our people. They are mutually interdependent.

The application of science and discovery make possible continuous advances and new achievements in prevention and control of disease—better medicine. There are, however, inherent limitations in medicine; physicians cannot create bodily immortality. Death cannot be prevented; it can only be postponed. All that the physician can do about death is to change age and cause. Proponents of nationalized medicine seem to assume that there is some absolute standard of medical practice and talk glibly of “adequate” medical care as if they could set a standard and a limit to medical progress. Medicine is not static. With other men here, I have seen changes in medicine in the past 50 years, during which time what was regarded as good medical practice has become entirely inadequate today. By the very nature of medical progress, it can never attain perfection, because the goal moves ever in advance. One thing is certain, however, you cannot improve medical care simply by setting up a uniform assembly line system—which always has and always will make it worse. Already in England there is now being advertised

private insurance to protect against the dangers and delays of government care. This indicates that even in Socialist England the people are finding that they must turn again to private enterprise to protect themselves against the evils of socialism.

This development in England is so significant that I wish to read a few sentences from an advertisement of the British United Provident Association which appeared in the *London Punch*, May 10, 1950.

“Which would you choose in the event of illness? Private treatment or the general ward!

“The National Health Service ensures that everyone receives medical and, if necessary, hospital treatment in the event of illness or operation.

“To many people, however, the necessary formalities, the waiting and, finally, treatment in a general ward, are disconcerting both in anticipation and in practice.

“In view of the fact that serious illness or the need for operation so often strikes without warning, it is no more than obvious wisdom to safeguard yourself and your family without delay. . . .”

We as physicians are resolved that the continuation of the marvelous progress in America shall not be thwarted or diverted by the introduction of a foreign ideology which, as in past decades, now elsewhere before our eyes, is destroying the quality of medical care and delaying the correction of obvious faults. We are well aware of the social and humanitarian necessity of provision for the health care of the indigent and the victims of ill fortune whose plight is due to both economic and medical factors. In former days this was accomplished by local communities and more recently by many excellent city and state aid programs, to which physicians already have given personal and professional support. This aid can be supervised best under local administration, and it then can reach the needy

Presidential address delivered before the House of Delegates, American Medical Association, San Francisco, Calif., June 26, 1950. Reprinted from the *Journal of the American Medical Association*, July 15, 1950.

without being diluted by the impositions encouraged by socialistic promoters of the welfare state. We already have achieved in this country the best medical care in the world.

Last month we were favored by the pronouncement of a spokesman for the political backers of government medicine to the effect that now they would be pleased to give up the program for compulsory sickness insurance if medicine could offer any other solution for improving the medical care of the nation. This is an official confession of the bankruptcy of the program plaintively described as "so close to the heart" of their political leader. Recent political events have no doubt played some part in recasting Act II of this modern political Comedy of Errors. An intelligent expansion of sound and helpful programs will succeed without unnecessary national legislation. We shall do best by encouraging more individual responsibility, more self help and fewer treacherous governmental crutches, more honest statements of fact and less deliberate deception and playing with the truth, more willingness to work and less national political tinkering.

Our Medical and Economic Problem

The objectives of medicine and their relation to our entire American economy are now much better understood by the people of this country than at the outset of our educational campaign. Let us review the progress of this critical fight of medicine and of all patriotic groups to defend our America from the external and internal attacks of socialism and its twin, communism. Prior to two years ago the insidious growth of socialistic practices promoted in the name of social and economic welfare had placed businesses, medicine, and even legitimate government on the defensive. In this gigantic malignancy a few ambitious but unscrupulous men did not hesitate to falsify statistics and sow seeds of discontent and distrust, audaciously using the familiar Marxian technique of the "misery of the masses" in a country the people of which are better fed, more prosperous, and more productive than in any nation in history.

The subjugation of medicine to political purposes has always been an early objective in the promotion of the socialist welfare state. Nibbling at the personal responsibility, initiative, and freedom of the individual by supposedly innocent and superficially attractive welfare measures went on for years without much opposition.

Physicians and others interested in the welfare of the public failed to recognize this process of undermining the originally strong pioneer spirit of our citizens. As professional men and as citizens we failed to realize the gravity of this attack on the moral foundations of our country. After the preliminary softening of the national fiber by alleged temporary welfare promises and benefits, the direct attack on medicine was intensified and medicine found itself in the front line in defense not of medicine alone but of the American way of life.

The Offensive

Now, after two years, the real threat of socialism is better understood by our citizens, and physicians together with other patriotic groups are on the offensive. Much of the previous national inertia which affected business and labor groups as well as medicine has been overcome. Thousands of non-medical citizens and leaders, at first impressed by the false premises of arguments for compulsory sickness insurance, now realize its inevitable destructive effects on quality of medical care, on the independence of the American citizen, and on the economic stability of the nation. Still others, though now informed, unfortunately hesitate to "lose face" by admitting that they were deceived. Members of the medical and allied professions are better united in understanding and in purpose than ever before and are determined that there shall be no shackling of medicine and no compromise with the evils of socialism.

A vigorous campaign for voluntary insurance by medically sponsored groups and by commercial insurance companies has brought hospital insurance to more than 68 million, and protection against surgical costs to 40 million and for medical costs to 16 to 18 million persons. Sixteen thousand persons are being added daily to those participating in voluntary health insurance plans. Meantime the professional accomplishments of the medical profession in the prevention and cure of disease have proceeded apace with continuing reduction of illness and lowering of death rates. This progress will be still more rapid when we have disposed of this socialist threat to America.

The general public has been made increasingly aware of the dangers of socialized medicine and socialism, and resolutions in opposition to compulsory health insurance and in favor of voluntary health insurance have been adopted by more than 10,000 organizations. More than 6600 are

non-medical and include farm bureaus, the American Legion, civic and women's clubs, religious groups, insurance groups, and other professional organizations. This is indisputable evidence of the disgust of thinking persons across this land, independently of the political parties, for the insidious socialistic programs which will cost the average man more in taxes than he can ever receive in benefits.

Confusion

A few months ago it became evident that a bill for the nationalization of medicine could not pass this Congress, and so the program of its proponents was changed and an attempt was made to introduce further fragments of socialism by means of small federal contributions to this or that new welfare agency. A number of such bills were introduced carrying almost no financial commitment, obviously intended to set up a pattern—a foot in the door—so that later these little bureaucracies could grow. In other bills it has been proposed to give federal aid to projects which affect many phases of our economic, educational, and medical life. Sometimes these proposals are urged on the basis of alleged need and at other times recommended as progressive social projects, often with the disclaimer of any present intent of local interference by government bureaucracy. No mention is made of the Supreme Court decision of 1942, which asserted the right of government "to regulate that which it subsidizes."

The American people would not now accept socialism as a substitute for our American democracy. However, there still is much confusion in the minds of the public and of many physicians as to the importance of the so-called fringe bills. For the past 15 years the American people have been conditioned to the gradual growth of welfare projects not only in medicine but in other fields of attempted economic planning, which historically in other nations have always ended in economic dictatorship. Economic planning and welfare projects have been promoted as devious alternative measures in preference to meeting economic and social difficulties on the basis of individual responsibility and incentive of each citizen.

Responsibility for the social welfare of our people, in which all physicians as well as public-spirited citizens are deeply interested, has been gradually shifted from the local community and the state to a federal bureaucracy on the falla-

cious ground that only federal government could take care of exaggerated claims of alleged tremendous gaps in social and medical care. Great advances in medical and social care already made at state and local levels are interiered with by severe taxation of a wasteful federal government which always exacts an excessive brokerage for the support of the ever growing bureaucracy parasitic on each project. Thus the public and the medical profession have been conditioned to progressive steps which tend to remove from group after group of our citizens the necessity of personal effort. This process of softening and regimentation, whether by direct subsidy or by federal loans to small businesses, has been tolerated by this nation more readily following its temporary regimentation by total war.

A welfare measure, superficially attractive and perhaps relatively innocent in itself, forms a precedent; it is then easy to add a further welfare measure on the supposition that it is similar and perhaps complementary to previous legislation. Thus it is not surprising that many physicians and other thoughtful groups find it difficult to determine where such legislation should stop. This difficulty is also encountered by members of Congress who in the past have taken positions of compromise, which no doubt were strategically expedient at the time but which have persisted to plague those who now see the entire economic and social picture more clearly. A number of laws with a socialistic trend were formerly favored by members of the Congress before they had opportunity to think things through.

The only sound and consistent position for American medicine and the American people is that of opposition to any measures related to the progress of the socialist welfare state. Worthy objectives have been habitually used to camouflage national proposals essentially dangerous to our medical, social, and economic well-being. These objectives can be attained more safely and effectively by local and state efforts after appropriate thorough education of the public.

The offensive battle of the medical profession, in addition to outspoken opposition to the socialization of medicine and the socialization of America, must include opposition to fringe bills. We must clear our thinking from the muddle in which it has been placed by the insidious growth of welfare measures of the past 15 years, many of which were surreptitiously planned as steps toward socialism. Help for the needy and dis-

tressed can be supplied without destroying their individual freedom and subjecting them together with their fellow citizens to slavery of the police welfare state.

The successful program of local and state service to the sick and needy must not be nullified by dominating interference of selfish federal bureaucracies. Programs for preventive medicine must be advanced and not diverted by the destructive effects of socialized medicine on the quality of medical service to the public.

National Solvency

Medicine will flourish and progress only in a sound economy. Our efforts, therefore, must concern not only the interests of good medicine but also the maintenance of free enterprise and solvent finance in American life. We must labor to maintain the personal freedom and initiative of our citizens. Our funds then will be available to help the needy and improve the conditions of other citizens by local measures; citizens will not lose their initiative and sense of personal responsibility to the state. In this national emergency, whether physicians or business men or farmers or laboring men, we must not be guilty of cowardice or unwillingness to stand up and be counted. We shall have to oppose even some of our medical friends who have been deceived by the rosy red picture of the welfare state.

This is not a partisan political fight; it is a crusade in which every right thinking doctor who values freedom of opportunity, free enterprise, and the maintenance of high standards of medical practice must join.

You, the members of this House of Delegates, represent all the states in the Union. It is by your efforts and influence that every doctor can be shown the part which he must play in the present crisis. We as physicians have traditionally shunned political activities. During war physicians have always joined in efforts to save our republic. Now is the time again to come to the rescue of our country, this time to help save it from socialism.

Physicians in every community must accept and take on the responsibilities of citizenship. First, they must register and then vote. A survey taken recently disclosed that 13 per cent of physicians in the localities surveyed were not

registered; in fact, 22 per cent did not vote. In this respect they are not different from other well meaning and patriotic groups; for example, 26 per cent of bank employees and executives were not registered and 32 per cent did not vote. The same survey revealed similar figures for pharmacists and ministers and for members of chambers of commerce.

We, as physicians, must pause in our practice long enough to inform ourselves of the issues which confront our country. We must realize that the country is being undermined by treacherous proposals initiated in the name of doing good. We must take an active part as citizens in our government. The problem is simply stated: Compulsory health insurance is socialized medicine despite recent frenzied political efforts to escape the issue. To socialize medicine is to socialize America. The effectiveness of our city, county, and state aid programs for the needy and indigent, the further development of preventive medicine, the rapidly growing professional and commercial voluntary insurance against the financial hazards of illness, the multitude of fraternal and religious charitable and self-help agencies, must not be jeopardized and ruined by the imposition of deceptive and wasteful socialistic proposals advanced by those who hope to profit politically at the expense of the freedom of the American citizen.

Do we as a people wish to rush down the socialist road after Great Britain? The answer obviously is "no," but we must present forcefully our convictions. We as physicians and citizens shall not relax until, with other patriotic groups in business, on the farm, in the other professions and labor, we shall have rolled back the socialist flood that threatens to engulf our American freedom and our solvency.

As I conclude my year of service as President, may I thank you again for the honor you have done me, for your own efforts in our crusade and, most of all, for your support, which has made a trying and difficult year much easier. Among the compensations have been the cooperation of the general medical profession and the unity of physicians and of other patriotic groups in our fight to maintain freedom of medicine and freedom of America.

SKIN DISEASES IN CHILDREN

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FROM infancy to adolescence almost every child has had some type of skin eruption at one time or another, and if we include the acute exanthemas the incidence would be much higher. Children manifest nearly all the cutaneous diseases encountered in adults, but certain eruptions are more common in the young. The average practitioner, when confronted with a skin disease in this age group, has a double problem inasmuch as he has to deal with two branches of medicine, pediatrics and dermatology, each of which is capable of taxing his diagnostic and therapeutic ability. Therefore, his approach to the subject usually follows a backward trend in that he thinks first of the detail man's panacea in the form of an ointment instead of utilizing his basic knowledge of symptoms, examining the patient, and making a diagnosis before rendering treatment.

A full discussion of skin diseases in children would cover a volume or more. The limitation of time prevents a comprehensive discussion of all juvenile skin diseases with their manifold phases; therefore, I shall present the most common ones encountered by the general practitioner in the course of his daily routine. For convenience and simplicity it will be more feasible to present the common diseases according to an etiologic classification, stressing treatment according to present standards.

The most common diseases of bacterial origin are impetigo, ecthyma, and furunculosis. Impetigo contagiosa is an acute contagious disease usually appearing on the face, although it may appear on any part of the body. The early lesions are superficial vesicles which soon become pustules. These quickly change to the typical honey-colored, pasted-on superficial crusts, varying in size from a split pea to a quarter. Occa-

sionally, bullous lesions are encountered which maintain their vesiculation longer, are more exudative, and extend over more widespread areas. Impetigo of the fingers and back of the scalp associated with adjacent adenitis complicates scabies and pediculosis capitis respectively. The diagnosis is made by the presence of yellow, rapidly spreading, sharply outlined superficial crusts. The disease leaves no scars.

Treatment consists of two phases, namely, prophylaxis and topical applications. The mother should be advised of the contagious nature of the disease so that spread to other members of the family will be avoided. Removal of the crusts with soap and water before each application of the medication is important. If exudation occurs, wet dressings of boric acid or Burow's solution are indicated prior to the use of ointments. Locally, 1 to 2 per cent ammoniated mercury ointment is the treatment of choice over the antibiotic and sulfonamide ointments because of the greater possibility of sensitization to these drugs. Other local drugs of value include vioform ointment and the aniline dyes.

Bullous impetigo of the newborn, incorrectly designated as pemphigus neonatorum, occurs suddenly and spreads rapidly by the appearance of flaccid vesicles and bullae in crops. These rupture leaving small and large erosions with surrounding undermined epidermis. Constitutional symptoms such as nausea, vomiting, diarrhea, and fever may occur. The disease has a high mortality, especially when epidemic in nurseries, where isolation and special nursing care are required. The milder cases are treated with 1 to 2 per cent ammoniated mercury ointment, aniline dyes, or calomel dusting powder. Generalized eruptions may require penicillin given parenterally.

Ecthyma is an ulcerative variety of impetigo which is deep-seated and leaves scars. It is most frequently seen on the lower extremities or but-

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tocks. Individuals in poor health and living under bad hygienic conditions are prone to the disease, which may be primary or secondary. The primary type begins with a vesicle, quickly changing to a pustule which ruptures and leaving a crust under which a seropurulent exudate remains. Lesions vary in number from a few to twenty or more. The secondary type follows the scratching of insect bites, scabies, pediculosis, or as a result of secondary infection of brush burns of the knees and shins. Treatment is the same as that used for impetigo together with measures tending to improve the child's general health such as the addition of vitamins, liver and iron therapy, as well as local ultraviolet and roentgen-ray applications as indicated.

Furunculosis (recurrent boils) is usually associated with undernourishment, poor hygiene, lack of rest, focal infection, diabetes, or anemia. Treatment consists of correcting hygiene and controlling local infection. Vaccines, penicillin, and sulfonamide drugs are indicated together with local applications and surgery when necessary.

During the past several years a nation-wide increase in the number of cases of tinea capitis has been encountered. The disease is almost limited to children and presents difficult problems of diagnosis and treatment. Two main types are seen: the human type caused by the *Microsporum audouinii*, and the animal type caused by the *Microsporum lanosum*. In the Pittsburgh district more than 90 per cent were of the human type in the recent epidemic. The infection occurs as scaly, slightly inflammatory patches varying in size from a split pea to a silver dollar or larger. In the involved areas the hairs break off and the scalp shows a fine scale. The less common animal type starts with similar lesions, but secondary pyogenic infection produces follicular pustules and at times kerions, painful boggy swellings of the deeper structures of the scalp. Ringworm of the scalp usually clears spontaneously at puberty and is very rare in adults.

Tinea capitis must be differentiated primarily from alopecia areata and syphilitic alopecia. Ringworm is progressive, while alopecia areata is sudden and the hairs from the edge of alopecia areata resemble exclamation points. A moth-eaten appearance is characteristic of syphilitic alopecia, associated with other specific signs and history. Examination with Wood's light (ultraviolet radiation passed through special Corning

glass) causes the infected hairs to fluoresce. When properly used, Wood's light is a valuable diagnostic aid and a guide to therapeutic results. The purple X bulb may be used in smaller clinics and offices, but has the disadvantage of short exposures. The bulb becomes very hot and may break, causing serious burns.

The type of fungus present requires a culture examination. The direct smear is a simple office procedure that may be used in diagnosis. Several infected hairs are placed on a glass slide, 20 per cent sodium hydroxide added, and a cover slip applied. After a 20-minute wait the spores may be seen under the microscope with reduced light.

Treatment of ringworm of the scalp varies depending upon the organism present. Plucking out the diseased hairs and applying locally sulfur, mercury, or salicylic acid usually suffice in the *Microsporum lanosum* infections. Infrequently a stubborn case may necessitate roentgen-ray epilation. The human type presents a more difficult problem. In the past few years dermatologists, experimenting with the fatty acids present in the hair and sebaceous secretions of adults, studied their use in the topical treatment of tinea capitis. The local medication—ointments of undecylenic acid and its copper salt, and propionic acid—should be rubbed in with a toothbrush twice daily. Progress is checked by monthly examinations with Wood's light. If the disease continues to spread or there is no improvement in treated areas within two months, roentgen-ray epilation should be carried out by an experienced operator. We advise against the use of thallium acetate for epilation and estrogens in children.

Tinea circinata usually attacks the glabrous skin; it consists of a single lesion, numerous lesions, or occasionally generalized. The eruption begins as a small macule spreading peripherally and clearing in the center with a fine vesicular border. The disease is usually contracted from household pets and caused by the *Microsporum lanosum*. The direct smear examination described above is diagnostic on finding the mycelia. The condition responds to local remedies including one-fourth to one-half strength Whitfield's ointment, fatty acid ointments, or tincture of iodine.

Dermatophytosis of the feet and hands is usually caused by an *Epidermophyton* or a *Trichophyton*, and is more common in older chil-

dren. Two types are seen: a vesicular type affecting the interdigital spaces caused by the *Trichophyton gypseum*, and the *Trichophyton purpureum* type characterized by scaling and patchy eczematization on the soles or sides of the feet. Treatment depends upon the stage of the disease. When there are acute vesiculation, inflammation, and exudation, wet dressings of boric acid, Burow's solution, or potassium permanganate (1-10,000) are indicated. During the subacute stage half-strength Whitfield's ointment or one of the fatty acid derivatives is useful.

Tinea cruris usually produces a palm-sized, sharply margined red patch at the upper part of the inner surface of each thigh. The periphery is scaly, while the rest of the area is smooth. Secondary infection may result in exudation. Treatment is the same as used in *tinea circinata*.

Tinea versicolor (chromophytosis or pityriasis versicolor), caused by the *Malassezia furfur*, affects the chest, back, and neck, producing fawn to yellow brown macules varying in size from split pea to palm to large sheets. The diagnosis may be confirmed by microscopic examination. The disease rapidly responds to the daily application of a 10 per cent solution of sodium hypofluorite.

Scabies, caused by the *Acarus scabiei*, is the most frequently encountered disease of animal parasite origin. The hands, wrists, anterior axillary folds, waist, buttocks, and feet are involved; the face and scalp may be involved in nursing infants because of the contact of the baby's face with the mother's infected breasts. The primary lesion is an excoriated papule complicated by crusts and areas of exudation. Benzyl benzoate and sulfur are effective remedies. Ten per cent emulsion of benzyl benzoate suffices for infants, 15 per cent for children. Sulfur should be prescribed as 2 per cent for infants and 3 to 5 per cent for children. To prevent reinfection, all washable clothes should be washed and all non-washables dry-cleaned or pressed. Overtreatment of scabies results in a chemical dermatitis.

Pediculosis capitis is caused by an animal parasite which cements its eggs to the shafts of the hairs close to the scalp. The condition may be complicated by impetigo, furuncles, and post-cervical adenitis which may hide the original cause. Neglected cases develop an unpleasant odor and crusted mats of hair. Diagnosis is made by finding the insects or nits. The simplest treatment is to dust 5 per cent DDT powder into

the hair and scalp. Toxic reaction from its use may be avoided by tying the scalp in a towel to prevent inhalation of the powder. Lotions containing benzyl benzoate and DDT are effective. Other medications include tincture delphinium and equal parts of kerosene and olive oil. Nits may be removed by a mild vinegar rinse, or a few minutes' soak in xylol followed by a shampoo and fine-combing.

Molluscum contagiosum is a virus infection involving the face, neck, and hands. The lesion begins as a pointed papule and grows to a waxy, semi-translucent, umbilicated lesion the size of a split pea. The disease is contagious and mild epidemics have been known to appear in institutions or schools. Treatment consists of expressing the contents of each lesion with a pointed scalpel or intramuscular needle. Recently the use of aureomycin has been tried with good results.

Of the allergic disorders in children, atopic eczema presents the most frequent problem and challenges the ability of the physician in charge. The history of the eruption is important and the age at which the eruption appeared gives the first lead as to the exciting cause. Those appearing under four months usually suggest a food allergy, the most common allergens being milk, wheat, eggs, fish oils, orange, and chocolate. Inhalant allergy is usually associated with the eruptions appearing later, most commonly caused by cat hair, dog hair, feathers, silk, and orris. Skin testing and elimination diets are of value in these cases. The usual areas involved in atopic dermatitis are the antecubital and popliteal regions, both sides of the face and forehead. In some cases the lesions occur upon the extensor surfaces of the elbows, thighs, and legs, and in other cases any part of the body may be involved. Treatment depends upon the stage. Wet dressings of Burow's solution and colloidal baths are used during the exudative or secondarily infected period; later, boric acid ointment or 3 per cent vioform ointment may be used in the subacute stage; and mild stimulation, 1/2 to 1 per cent tar, is prescribed in the chronic period. Antihistaminic drugs are of value. Competitive sports should be avoided by the atopic child; his energies should be diverted into less rigorous fields such as music, reading, hiking, chess, and checkers.

Papular urticaria (*lichen urticatus*) is the most baffling of the erythema group. The diag-

nosis is made from the appearance of the primary lesion, a pinhead papule or vesicle appearing in the center of a small wheal or erythematous macule. Excoriations, crusts, and adenitis follow the scratching. The disease is usually limited to the arms and legs, but may affect any part of the body. The condition may last several months or be recurrent each spring or summer for several years. Allergy surveys in a large number of cases yielded no specific etiology and are not advised routinely. Treatment consists in general measures to improve the child's health, local antipruritics such as ½ per cent menthol in calamine lotion or liniment, and antihistaminics. Recently the use of moccasin venom in small doses by injection has been reported of value in resistant cases.

Erythema multiforme, a more common member of this group, appears in the form of macules, margined patches, and erythematous sheets with or without configuration and the typical iris lesions. Malaise and elevation of temperature may precede the eruption. Subjective symptoms include itching, burning, fever, nausea, diarrhea, headache, constipation, loss of appetite, and joint pains. The mucous membranes are often affected. Chronic toxemia from food, foci of infection, drug eruption, and gastro-intestinal disturbances are etiologic factors. Treatment is palliative, consisting of salicylates, antihistaminics, cathartics, intravenous calcium gluconate, and local soothing lotions.

Diaper eruption (erythema of Jacquet) involves the inner surfaces of the thighs and genitals, sometimes spreading to the perineum, buttocks, legs, and heels. Wet diapers, decomposition of urine produced by fecal bacilli, and strong alkaline soap left in napkins after washing are factors. The eruption varies in severity from a bright red erythema to papular lesions, vesiculation, secondary infection, and ulceration. Treatment requires care of the napkins by thorough rinsing after washing and soaking in boric acid solution. Locally 2 per cent vioform in calamine lotion or a mildly antiseptic dusting powder may be used.

Urticaria and angioneurotic edema are uncommon in children. Urticaria pigmentosa usually develops in the first year of life. Wheals appear and persist for several weeks, leaving yellow or brown macules varying in size from a split pea to a dime. The number of lesions varies from a dozen to innumerable and they are usually lim-

ited to the trunk. The disease usually disappears at puberty. Treatment is palliative—soothing local remedies to allay itching.

Because of the time limitation, I have omitted the congenital anomalies, pigmentations, and new growths, as well as the scaling dermatoses in which the problems of diagnosis and treatment are the same as those encountered in adults.

ABSTRACT OF DISCUSSION

HENRY H. PERLMAN (Philadelphia): If the progress of medicine in any department is to be measured by its innovating activity and fruitful accomplishment, then surely pediatrics must be accorded a place in the vanguard of progress. Certainly pediatrics has been very much alive these past years; and indeed, it needs to be alive to an extraordinary degree because a large part of its work lies in the assimilation of the tremendous medical advances that are constantly occurring in all the other fields to its own special subject matter. Therefore, it ought not to be surprising that specialties have developed within the specialty of pediatrics.

As you know, there are now pediatric gynecologists, pediatric surgeons, pediatric endocrinologists, pediatric ophthalmologists, child psychiatrists, and dentists specializing in children's orthodontia. Further, the American Board of Dermatology and Syphilology has certified in its specialty two former licentiates of the American Board of Pediatrics. In brief, pediatrics, together with the medical profession as a whole, has become increasingly "specialty conscious." Of course, there are those who deplore the specializing trend. On the other hand, the general pediatrician who often has had to face up to unusual problems and felt his own inadequacy to handle them is glad for the existence of these emerging points of special referral within the pediatric specialty. And the laity, who also have felt the same need, although more obscurely, look with an increased assurance to the profession. On these grounds it appears that a great deal can be said on behalf of "high specialization." The final and unbeatable argument for it is, of course, that it brings to difficult problems pertinent knowledge and experience.

But to forward its desirable ends, specialized training must be shared as widely as possible. Therefore, it is to be hoped that those responsible for graduate instruction will act to make courses easily available to those who can best benefit from them. For example, the dermatologic specialty affords a first-rate instance of a comparative failure to provide facilities for training the general pediatrician. The pediatrician usually knows little of dermatology. Perhaps he has been conscious of his lack and has been seeking training but has not known where to obtain it. Indeed, unless such training is provided in the outpatient department of a large hospital, it is unobtainable. It happens that a course in the diagnosis and treatment of skin diseases in infants and children will be offered this year in the postgraduate school in pediatrics at the University of Pennsylvania. This course, consisting both of weekly didactic lectures and practical conferences, has enjoyed an increasing

popularity among graduate students for the past four years. It is cited as the sort of course that ought to be set up in all medical schools and in all the relevant specialties in order to pass along to the general pediatrician a measure of the new specialized knowledge that he needs.

At all times the physician should remember (and this is the heart of the pediatric problem as it reaches out in other specialties) that the child is not a miniature adult. Rather he is characterized by his differences from the adult. Obvious are the differences of height and weight, of muscular development and mental growth. Less obvious but considered are other differences, like those of emotional temper and recuperative power. But there are still other differences which tend to be overlooked, like the growing tissue response of the child, so different from that of the adult. Yet because of it the most careful consideration ought to be given when one is prescribing a topical remedy for a young child; and by the same token, special thought must be taken, too, to modifying in the interest of the child's skin a topical remedy which is indicated for the treatment of that skin disorder. Because of the failure of care on these counts, it is no exaggeration to suggest that perhaps more young skins are traumatized, or at least worsened, through the indiscreet prescribing of remedies than are injured by the dermatoses themselves.

It is against the prevalence of such unfortunate conditions that postgraduate courses in pediatric dermatology should be planned. Their utility is that they can help to put into greater circulation specialized knowledge of real importance. There should be many such courses with reference to all the specialties. One thing we may be sure of: specialization has come to stay. Our great problem in respect to it is to secure the proper distribution of its contributions. One path to that end certainly lies through more specialized courses for the general pediatrician.

I wish to congratulate Dr. Perrin for his excellent and masterly presentation of a timely and difficult subject.

THEODORE MELNICK (Philadelphia): I only want to say a few words in reference to what Dr. Perrin said about atopic eczema in children. The longer I am in practice the more I am convinced that a little procedure that I follow is the preferred way as compared to that which is the customary procedure of some of my colleagues. When the time comes for a baby to receive additional food, when milk alone is not sufficient for growth and development, some of my colleagues will advise the mother to add cereal to the child's diet, also vegetables, fruits, and some other ingredients. I do not add a large number of food substances. I only suggest one ingredient at a time for a period of three or four days. I tell the mother that I am not aware of her child's sensitiveness and that is why we have to be cautious and actually experiment with each and every food. I may add a cereal for three days and a vegetable for another three days, that is, one vegetable at a time for a three-day period, and so on. In that manner, should any skin eruption develop, I know what the

offender is. I immediately stop the use of that particular food substance, and before many days have passed the skin eruption will disappear. I think that is the best method of controlling dermatitis in children, especially when you have to add solid food substances.

With reference to impetigo and diaper rash, the quickest treatment, without causing a sloppy condition of the buttocks, is to use the ultraviolet light. One or two exposures will clear up the condition and no medication will be required.

I should like to tell Dr. Perlman, if I may, that he can add another case to his list of recoveries with the use of undecylenic acid.

WILLIAM B. GUY (Pittsburgh): In connection with the epidemic of tinea capitis in Hagerstown, Md., the Public Health Service made a search for the vector of the organism responsible for the epidemic. Suspecting theater seats as one possible source of contact that these youngsters were encountering, they took the Wood light into many theaters in Hagerstown, but did not find the expected number of fluorescent hairs. In invading the barber shops, however, they did find that the clippers harbored numerous fluorescent hairs which on direct examination contained fungi.

The disease frequently begins in the clipped area, and I think it is more frequently seen in boys than in girls. This is probably because girls do not frequent barber shops as much as do boys.

The Public Health Service recommends as a method of prophylaxis that clippers be immersed in hot oil, at a temperature of 80 degrees or higher, but that is a procedure which I doubt any barber would agree to adopt. I suggest to my patients—and I carry out this procedure in my family—that they make sure that the barber uses only the scissors in cutting their hair. It takes a little more time and one has to tip them more, but they will do it. I also recommend a thorough soapy shampoo immediately upon coming home from the barber shop.

CLAUDE P. BROWN (Philadelphia): We have been studying the problem of diaper rash, but have not gotten around to the bacteriology involved until recently, so I am not in a position to give any figures. But there are a few things of which I am convinced. In view of the fact that the diaper laundries send out millions and millions of diapers, some of them as many as a million a week, I am convinced that the antiseptics which they use, except possibly in the rare instance, maybe one in a million, are responsible. Undoubtedly, the bacteria—not any particular one, but any of the ammonia-producing organisms—start the irritation. After the irritation has been continuous, such a variety of organisms may be found that I do not believe we can pin the blame on any particular one. I think, however, that the *Staphylococcus aureus* is the greatest offender in prolonging the dermatitis. During this recent study we have been suggesting that the doctor advise the mother to simply leave off the child's diapers. Maybe the mother will have a little more trouble, but if she follows the doctor's advice, no medicaments will be required because the rash will clear up.

THE DIAGNOSIS OF CANCER

An Evaluation of Some of the Newer Techniques

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THE SUBJECT of the diagnosis of cancer will be introduced by affirming and emphasizing the conclusion to be reached after reviewing recent developments in this field, namely, that an adequate biopsy, interpreted by a competent pathologist, remains the one most widely applicable method of diagnosing cancer, one which should be practiced in every instance where it is possible and where it is not specifically contraindicated. The accuracy of diagnosis based on good, permanent sections approximates 99 per cent. Frozen sections may be virtually as accurate when applied in certain limited fields, as, for instance, in the diagnosis of lesions of the female mammary gland, where the pathologist has ample opportunity to gain a broad experience, but their accuracy falls off sharply when their use is extended to the less frequently encountered tumors, where the range of differential diagnosis may be almost unlimited, as, for example, with the difficult and varied sarcomas of the soft parts.

There are many techniques by which biopsy may be performed—almost all of them useful in specific situations. Some techniques yield better results than others in the hands of certain individuals, individuals especially experienced and skilled with those particular techniques. All of the biopsy methods have in common the fundamental requirements that the specimen submitted to the pathologist be representative of the lesion under investigation and that there be cooperation and sympathetic understanding between clinician and pathologist.

Mechanical aids in processing biopsy tissues, permitting the preparation of good paraffin sec-

tions in a minimum of time, are in widespread use and are, no doubt, familiar to all. Certain technical developments may not be as well known. Blank¹ has recently reported a method which not only promises to be rapid but appeals further because of its simplicity. This method, utilizing a mixture of polyethylene glycols marketed as "Carbowax," eliminates tedious dehydration and hydration and permits the preparation of sections comparable, at least under certain conditions, to paraffin sections within five hours. Such a schedule is, of course, not applicable to a large volume of material, but it may prove very helpful in particular instances where speed is vital and further experimentation may result in a wider field of applicability.

A staining technique has been the subject of a report by Ayres,² who has used an azure C stain of fresh tissue as an adjunct (particularly to frozen sections) in the study of fine cytologic details, notably nucleoli. He considers the method particularly helpful in distinguishing mesothelium from cancer cells in pleural and peritoneal exudates. Certainly, we need help in making this difficult distinction, but it must be confessed that our own trials with Ayres' method, although influencing our opinion in a number of cases, have not resolved genuine doubts of cell identities.

New instruments offer fascinating possibilities. The electron microscope, with a resolving power 100 times that of the ordinary light microscope, permits study of cell details completely invisible otherwise. As yet, however, this instrument is a research tool and its potentialities, specifically its possible applicability to routine cancer diagnosis, remain to be assessed. Essentially, the same thing is true of the phase microscope, although von Albertini³ and Richter⁴ have called attention to special practical applications. Von

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Albertini has found it particularly useful in the study of squamous cell lesions because of the readiness with which certain fine details, especially intercellular bridges, can be demonstrated. The loss of such details may provide minute evidence of the cancerous or precancerous nature of some squamous cell growths. Richter states that cross-striations are much more easily seen in tumors of skeletal muscle origin with the phase microscope than with the light microscope. Although the practical usefulness of the phase microscope appears too limited at the present time to warrant its widespread use for purely diagnostic purposes, nevertheless, further investigation promises much.

There are many methods, some of them of recent development, of studying the biologic behavior of tumors. They include tissue culture and cultivation of tumors in the chick embryo after intravenous inoculation or in the yolk sac of embryonated eggs. The latter two techniques have not been applied to routine diagnosis, but Stout and Murray have made great contributions to our knowledge of certain tumor types and to our ability to diagnose them by observing growth characteristics *in vitro*.^{5 to 12} They have used tissue culture essentially as an investigative method, but it has proved of practical diagnostic value in their hands in differentiating the sympatheticoblastoma (or neuroblastoma) from lymphosarcoma, Ewing's tumor, and small-celled carcinoma consistently and usually within 24 hours.¹³ Grace¹⁴ has found tissue cultures helpful in assessing the degree of malignancy of various neoplasms, especially Hodgkin's disease. That the tissue culture method may be useful in cancer diagnosis and prognosis is clear; nevertheless, it would seem that its chief worth is as a research weapon and that its field of practical application to routine diagnosis is too narrow to warrant the cost of equipping and maintaining an adequate laboratory for this purpose alone. Furthermore, the conduct of such a laboratory and the interpretation of cell behavior *in vitro* require the services of an individual with long familiarity and experience with the method, a requirement that cannot be met readily.

A number of workers have studied human tumors by the method of heterologous transplantation developed by Greene,¹⁵ who has used the ability of a human tumor to grow in the anterior chamber of the guinea pig eye as a measure of the autonomy of the tumor. Greene has advocated the use of this method as a routine

procedure in the clinicopathologic study of the patient with malignant disease. He reports that some tumors of uncertain nature have differentiated progressively in the guinea pig eye, their true nature thus eventually becoming evident. Similarly, he regards the demonstration of autonomy, by growth in the eye of alien species, as a more sensitive indicator of malignancy than histologic evaluation.¹⁶ Other writers have been unable to duplicate Greene's results and, in general, have not found the method helpful as a diagnostic procedure.

Eichwald¹⁷ obtained successful growth of only one of the 27 tumors of children (one "take" in 158 guinea pigs). Similar results have been obtained in this laboratory by Eisenberg. Fig. 1-A is a photomicrograph of a successful "take" of a gastric carcinoma in the anterior chamber of a guinea pig eye—the only unequivocal success among 20 tumors with which heterologous transplantation was attempted in 116 guinea pigs. Five equivocal "takes" of three tumors, which grew for a short time after transplantation and then remained stationary, showed no active-looking tumor on histologic examination (Fig. 1-B). One of these three tumors was a neurofibroma. At the same time one of two animal tumors, a mouse fibrosarcoma, grew aggressively in the anterior chamber of two of the three guinea pigs into which it was transplanted.

Other reports indicating a low percentage of successful intra-ocular transplants have been published by Dyer and Kelly¹⁸ and Lushbaugh and Steiner.¹⁹ The latter suggest that failure of a tumor to grow on heterologous transplantation may be a matter of short life span of the type cell and susceptibility to adverse conditions and antibody action, rather than the result of a lack of a high degree of malignancy or autonomy. Schilling and his co-workers,²⁰ in a recent review of the subject, also conclude that heterologous transplantation is not reliable as a routine diagnostic procedure because of the frequency with which truly malignant tumors fail to grow. They report growth of eight of 36 human malignant tumors in 29 eyes of 20 guinea pigs. Nineteen of the 36 tumors were simultaneously transplanted into tissue culture and 15 of them grew in this medium. In a number of their cases intra-ocular growth was delayed as long as four months. These authors list infection, extreme desmoplasia, and improper selection of tissues as known factors adverse to heterologous growth but having no relation to



Fig. 1. (A) Successful transplant of human gastric carcinoma in the anterior chamber of the guinea pig eye. The transplant grew progressively until the animal was sacrificed. Attempts to sub-transplant the growth into the eyes of other animals were unsuccessful. H. and E. $\times 120$. (B) Transplant of human osteogenic sarcoma in the anterior chamber of the guinea pig eye four weeks after transplantation. The tumor grew for a brief period, then remained stationary. Although spicules of atypical bone are seen in the mass, malignant cells are not identified. (The patient has died with pulmonary metastases.) H. and E. $\times 120$.

autonomy or degree of malignancy. These criticisms do not mean that the method does not have great merit as a technique for studying the biologic behavior of certain tumors, their reactions to certain environmental influences, etc. Furthermore, the fact of growth in the heterologous eye is definite evidence of a high degree of autonomy.

Probably the most widely used and the most discussed of the more recently developed methods of cancer diagnosis is the cytologic method revived and popularized by Papanicolaou.²¹ I say revived because the method is an old one, although many improvements, refinements, and modifications have been added since Papanicolaou's recent stimulus. There is now no doubt that cancers of many organs, some of them inaccessible to biopsy, can be diagnosed by the study of smears. All that remains is to define the fields of greatest usefulness of the method and to learn its limitations.

The earliest applications of Papanicolaou's technique were concerned with the study of the female genital tract. Papanicolaou's demonstration of the feasibility of diagnosing cancer on vaginal (or cervical) smears has been repeated by many workers. There are, however, many cases of uterine cancer in which the diagnosis is not made on cytologic study and such cases are of great importance in evaluating the controversy that has arisen concerning the use of smears in "screening" groups of asymptomatic women. The important limitation here is the "false negative" which Rakoff²² reports as high as 30 per cent. Wiles and Hellwig²³ also refer to the high per-

centage of false negatives as being the chief objection to the use of the method as a screening procedure. Boyd²⁴ also has emphasized the false negative, warning against overenthusiasm and the danger of creating, in patient and physician, a false sense of security. In our laboratory we failed to recognize cancer cells in smears from 16 per cent of the uterine cancer cases we studied.

At this point, it might be well to emphasize the fallacy of paying too much attention to statistics regarding the accuracy of smear diagnosis, a fallacy first pointed out by Gates and Warren.²⁵ A majority of errors in smear diagnosis are due to the failure to diagnose cancer when present (false negatives), either because the lesion fails to shed cancer cells or because the examiner fails to recognize them for what they are, for one or another reason, such as poor technique, good differentiation, or inexperience. Therefore, accuracy, expressed by a percentage, will vary with the source of the material. The accuracy will be much greater in a series of well, asymptomatic people than if the method be used only in the study of patients with symptomatic lesions. The "false positive" vaginal or cervical smear (Fig. 2) need not be as significant a limitation of the technique as is the "false negative" so long as we adhere to the dictum of corroborating all positive smear diagnoses by biopsy or curettage. The use of the terms "false negative" and "false positive" seems undesirable to the author since they tend to give the examination of smears the status of a "test," which it is not. The "false negatives and positives" represent either failure to diagnose cancer (for one of the reasons noted above) or misinterpretation—a mistake. Nevertheless, the terms are firmly rooted in the lit-

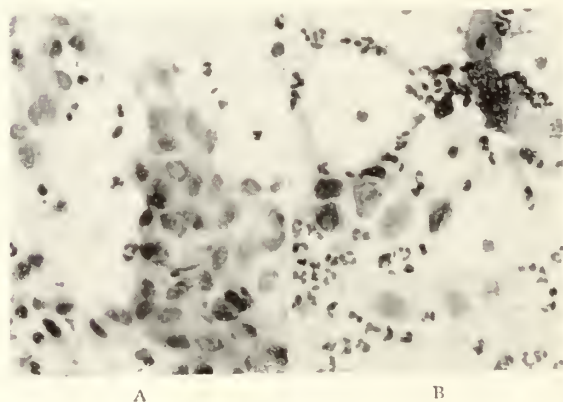


Fig. 2. (A) "False positive" smear from human cervix. Repeated smears had this appearance, but complete study, including curettage and biopsy, disclosed no explanation. We now doubt the malignant nature of these cells. Papanicolaou stain $\times 620$. (B) Smear from patient with proved epithelioma of the cervix. Papanicolaou stain $\times 620$.

erature and in the thinking of most of us and will, no doubt, be continued in use.

Gates and Warren²⁵ have suggested that vaginal and/or cervical smears may be especially useful in the study of obscure conditions that cannot be diagnosed by the usual means and for continued study, over long periods of time, of borderline lesions. The smear may well be of great help in providing further information about the carcinoma in situ, a lesion that undoubtedly exists but remains incompletely understood.²⁴ Graham²⁶ has used smears to evaluate the response to radiation therapy of carcinomas of the cervix by determining the immediate reaction to treatment. Our limited experience along this line points up the difficulty of correlating imme-



Fig. 3. Small epithelioma of branch bronchus to upper lobe of lung—inaccessible to bronchoscopy.

diate reaction with prognosis, a difficulty enhanced by the mutual resemblance of radiation effects and malignant characters in individual cells.²⁵

The cytologic technique has been applied to many secretions and excretions other than those of the female genitalia. It would appear that it is of the greatest practical usefulness in the diagnosis of cancers inaccessible to biopsy—most notably those of the lung and bronchus beyond the reach of the bronchoscope (Fig. 3) and those of the prostate gland. Herbut²⁷ reports the

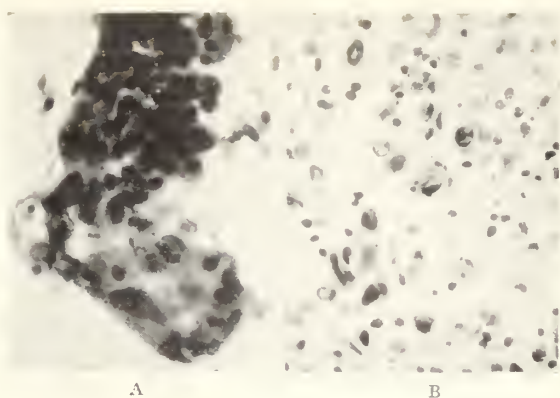


Fig. 4. (A) "False positive" smear of bronchial secretions. Papanicolaou stain x 620. (B) Section of lung of same patient, showing the atypical phagocytes which, in the smear, were incorrectly regarded as malignant cells. H. and E. x 620.

diagnosis of 90 per cent of bronchogenic cancers by the cytologic study of material aspirated from the bronchi. I doubt if many of us can achieve as good results, at least not until we have put in sufficient time and study to attain a comparable degree of experience and skill. Even so, it is of great significance that we can approximately double the percentage of bronchogenic carcinomas positively diagnosed preoperatively by utilizing smears in those cases in which the bronchoscopist can neither see nor take a biopsy specimen of the tumor.^{27, 28} A corollary to this is the fact that, whereas only a few years ago we believed that two-thirds or three-fourths of lung carcinomas might be diagnosed by bronchoscopic biopsy, today we find that appreciably less than half can be so diagnosed. This difference undoubtedly reflects the earlier recognition of bronchogenic cancer, recognition when the tumor is small and peripheral, before it has grown into the field of view of the bronchoscopist (Fig. 3).

A word of warning should be issued about

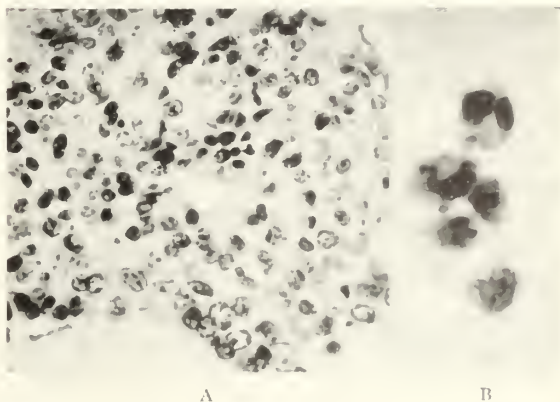


Fig. 5. Squamous cell epithelioma of bronchus. (A) Section of material aspirated from bronchi after concentrating and embedding in paraffin. H. and E. x 620. (B) Smear of bronchial secretions. Papanicolaou stain x 620.

the "false positive" smear of bronchial secretions. A number of these errors have been reported by others,^{29, 30} and we have made one such mistake in a patient with organizing lipoid pneumonia. Phagocytes with unusually large, irregular, and hyperchromatic nuclei were erroneously interpreted as cancer cells (Fig. 4). The error was made early in our experience with the method, and has undoubtedly served to increase our conservatism, accounting in some degree for the fact that we have diagnosed only two-thirds of the bronchogenic cancers that we have studied by the cytologic method alone. In addition to that one frank mistake, we have encountered one case of bronchogenic carcinoma in which the diagnosis was correctly made on smear but in which, I am convinced, the diagnosis was made on squamous cells that were metaplastic and not malignant at all. The tumor was an adenocarcinoma.

We have had no experience in our laboratory with smears of prostatic secretions, but cytologic study would appear to be of especial importance in this regard, since the end results of treatment of prostatic cancer are so poor, largely because the disease is invariably advanced by the time it is recognized by conventional means. Our experience with aspiration biopsy of the prostate has been disappointing, whereas Herbut³¹ and Albers and associates³² have reported very encouraging records in the interpretation of smears from cases of prostatic cancer.

Although most cancers of the lower part of the urinary tract are subject to visualization and conventional biopsy, the cytologic method has been reported as applicable to tumors in this location and, more to the point, the inaccessible tumors of the upper part of the urinary tract.³³

It is difficult to understand the advantages of cytologic studies of lesions of certain locations, as, for example, the rectum, where present methods are adequate and reliable. Similarly, pathologists have been identifying malignant cells in exudates removed from the serous cavities for many years. However, Saphir³⁴ prefers the cytologic method for pleural and peritoneal effusions, believing it more reliable as well as more rapid. Examination of gastric secretions has enjoyed only limited success, various writers reporting the ability to recognize from 37 to 86 per cent^{35, 36, 37} of gastric cancers by means of smears. Despite the possibilities of improvement with experience,³⁷ the false negative group is still so large that we should continue to regard every

gastric lesion as cancer until proved otherwise.

There have been many modifications of Papanicolaou's technique. Ayre's³⁸ "surface biopsy" method, using a wooden spatula to scrape the surface of the cervix, has permitted greater accuracy in the diagnosis of cervical lesions than examination of vaginal secretions alone. Hunter and Richardson's³⁹ technique of concentrating the material to be examined, handling the concentrate as a block of tissue and preparing paraffin sections, has appealed to the author (Fig. 5), although his associates continue to express preference for smears. Perhaps, as with the question of pleural and peritoneal exudates, each individual should rely upon the method best suited to him and with which he obtains the best results. Gladstone's⁴⁰ recently published method of "sponge biopsy"—obtaining tissue juices on an absorbable protein sponge, and sectioning sponge and specimen by routine methods—should interest the pathologist, since it should retain tissue and intercellular relationships, so important for diagnosis to most experienced pathologists, far better than is possible in smears.

The statement that a negative report on a smear (no matter what organ its source) should never be accepted as excluding cancer will bear reiteration. Conversely, cancer therapy, which means radical surgery or intensive radiation, should never be undertaken on the basis of a smear diagnosis alone. Such a diagnosis should be confirmed by conventional biopsy methods wherever possible; where that is not possible, the diagnosis should have the support of clinical data.

No discussion of cancer diagnosis can be complete without reference to the iodoacetate index developed by Huggins and his associates.⁴¹ The newspaper publicity attending Huggins' announcement suggested that this "test" met the urgent need for a simple serologic test for malignancy, comparable in accuracy to the commonly used tests for syphilis. The sera of all of the patients with active malignant disease studied had an iodoacetate index distinct from those of normal patients and patients with most non-malignant diseases. The only conditions yielding results comparable with those of cancer were certain acute and chronic infections readily diagnosed, such as active pulmonary tuberculosis. The authors made no claim of a "test" for cancer, and subsequent work has proved the propriety of their conservatism. Jones, working at the Hospital of the University of Pennsylvania,

has essentially confirmed Huggins' work—demonstrating a definite alteration of the proteins in the sera of patients with malignant disease. However, many exceptions have been encountered, the sera of many cancer patients having high iodoacetate indices falling within the normal range. The validity of the "test" is therefore by no means universal, and the precise place of this reaction in the diagnosis of cancer has yet to be determined.

Summary

New instruments and newly developed techniques and methods have contributed greatly to our knowledge of malignant disease and promise to contribute even more in the future. They have contributed something less, but contributed, nonetheless, to our ability to diagnose cancer in the living patient. With regard to practical cancer diagnosis, the cytologic method, popularized and applied by Papanicolaou, is the most important recent development. With all of these recent improvements, and especially the cytologic method, it is important to remember that biopsy is still the surest way of diagnosing cancer and should be applied in every instance possible.

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EDITOR'S NOTE: A complete bibliography containing 67 references will be supplied by the author upon request.

SYPHILITIC AORTITIS

Diagnosis by Means of Ascending Aortic Calcification

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IN 1945 THE author in conjunction with Lubert reported the frequent association between syphilitic aortitis and calcification of the ascending aorta as demonstrated roentgenologically. The significance of the calcified ascending aorta both at autopsy and in clinical cases was discussed. Up to the time of publication of this article no other such statistical analysis of the subject had been made and its diagnostic value not appreciated.

The present paper is concerned with the clinical and serologic findings in cases in which routine chest x-ray examination revealed this type of ascending aortic calcification. Some of these patients were suspected of having cardiovascular disease. Many were not. In all, 20 such individuals presented themselves. Aneurysms were, of course, excluded. Calcification in the walls of aneurysms is a common and well-known finding. The average age of the group was 56 years; there were 6 females and 14 males; 17 were white and 3 colored. The serologic reaction at the time of examination was positive in fifteen (75 per cent) and negative in five (25 per cent), although three of these gave a history of treatment. Ten had a murmur thought to be aortic in nature. In several the aortic murmur was elicited only after the chest x-ray findings suggested syphilitic aortitis. Three had aortic insufficiency.

These figures are in accord with the previously published statistics by the author¹ and are also quite similar to those of Leighton² and of Lenegre, Kilaidonis, and DeBrux.³

The age incidence, serologic reactions, and clinical evidence of aortitis are in essential agreement. The number of patients with calcification in the ascending aorta showing positive serologic

reactions is too high to be coincidental. Reid found positive Wassermann reactions in 83 per cent of patients with cardiovascular syphilis shortly before death. If the radiologist finds calcification in the ascending aorta, syphilis can be predicted with considerable confidence and will usually be confirmed by a positive serologic reaction and/or clinical examination. Absence of aortic insufficiency by no means precludes the diagnosis of aortic syphilis. The clinical diagnosis can be made only if the infection does one of three things:

1. Produces an aneurysm which presses on something.
2. Causes insufficiency of the aortic valve.
3. Closes the ostium of a coronary vessel.

Further proof of the above contention may be obtained at autopsy. Between 25 and 50 per cent of cases of syphilitic aortitis will show ante mortem calcification of the ascending aorta on routine chest x-rays. This point has been brought out previously.

TABLE I
CASES SHOWING CALCIFICATION ON ROUTINE
CHEST EXAMINATION

	<i>Serologic Reaction Positive</i>	<i>Clinical Evidence of Aortitis</i>
Jackman and		
Lubert, 1945 ..	65% (13 of 20)	25% (5 of 20)
Leighton, 1948 ..	62% (13 of 21)	30-90% (12 of 13)
Lenegre et al.,		
1948	66 $\frac{2}{3}$ % (20 of 30)	Not stated
Present series ...	75% (15 of 20)	50% (10 of 20)

Case Reports

CASE 1.—B. R., white female, age 63, consulted her physician because of epigastric distress. She was referred for gastro-intestinal examination. The routine preliminary fluoroscopy of the chest revealed calcification of the ascending aorta. There was no evidence of

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Fig. 1

aneurysm and the diameter of the aorta, as measured on the film (Fig. 1), was 3.2 cm. There was no aortic murmur. The patient had Argyll Robertson pupils. There were no other signs of syphilis. The blood Wassermann reaction was 4 plus.

CASE 2.—W. S., white male, age 64. A chest film was requested because of cough and weight loss. Linear calcification of the ascending aorta was demonstrated on the routine postero-anterior film (Fig. 2). Subsequent investigation, when syphilitic aortitis was suggested, revealed a history of a primary lesion 30 years before which was inadequately treated. The serologic tests for syphilis were all strongly positive. An aortic murmur was present.



Fig. 2

TABLE II

CALCIFICATION OF ASCENDING AORTA IN SYPHILITIC AORTITIS—AUTOPSY FINDINGS

	Serologic Reaction Positive	Calcified Ascending Aorta
Jackman and Lubert, ¹ 1945	80% (49 of 61)	22.7% (15 of 61)
Leighton, ² 1948 ..	80% (16 of 20)	50% (9 of 18)

Control

For the purposes of control, 200 films were drawn from the files and reviewed. They were selected only to correspond in age and sex with the above groups. Three of the group had positive Wassermann reactions. This incidence is approximately the same as noted on routine hospital admissions. In a similar control series, Leighton's² findings were much the same as in this series.

In approximately 50 per cent, calcification of the knob was visible, but none showed ascending aortic calcification.

Discussion

It is beyond the scope of this paper to discuss the relationship between arteriosclerosis and syphilitic calcification of the aorta. From the standpoint of the radiologist two distinct differences are present: syphilitic calcification occurs in the ascending aorta and is linear in type; arteriosclerotic calcification occurs distally on the left side of the arch and is spotty in distribution. Pathologically, it is known that the aortic root is attacked early in syphilis and that the calcification which we see is likely part of the healing process. The calcification is a late syphilitic manifestation occurring years after the primary lesion. Whether the calcification found roentgenologically in the ascending aorta is the result of syphilitic aortitis or the sequel of an arteriosclerotic process initiated by the syphilis is unknown. At any rate, the diagnosis of syphilitic aortitis can be made with acceptable accuracy by the radiologist if the calcification is demonstrated. Its absence is of no significance.

Conclusion

The x-ray demonstration of calcification of the ascending aorta is a reliable diagnostic sign of syphilitic aortitis.

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Clinical Aspects of Congenital Heart Disease

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THE DIAGNOSIS of congenital heart disease is fairly obvious in the individual who presents cyanosis and clubbing in association with abnormal cardiac findings. However, the majority of individuals with cardiovascular anomalies are not cyanotic. In such cases the presence of a congenital lesion may be suspected when a systolic murmur, usually high pitched or rough and vibratory, is heard best to the left of the sternum rather than at the apex, where the murmur of an acquired mitral lesion is best heard. Such a murmur is usually maximum in the pulmonary area in association with pulmonic stenosis or an interatrial septal defect, and heard best to the left of the lower sternum in association with an interventricular septal defect. It should not be confused with the juvenile functional murmur which is also best heard to the left of the sternum, but has a characteristic low-pitched musical twanging component. A continuous machinery murmur below the left clavicle may indicate the presence of a patent ductus arteriosus. The diagnosis of coarctation of the aorta will never be missed by the physician who makes a practice of checking blood pressure in the legs when hypertension is noted in the arms or who routinely feels for pulsations in the femoral arteries.

Cardiovascular anomalies may be divided into three major groups (Table I). Lesions in Group 1 are associated with no defects permitting the mixture of venous and arterial blood. All septa are intact; the ductus arteriosus and foramen ovale are closed. Anomalies of the aortic arch and coarctation of the aorta belong to this group. Group 2 includes septal defects or persistent patency of the ductus arteriosus, not complicated by associated anomalies which may change the normal pressure relations within the heart. Blood is shunted through the defect from the arterial to the venous side of the heart or great

vessels. The circulating volume of blood within the lungs is therefore greater than that within the systemic vessels. Group 3 includes all defects in which the heart is so maldeveloped as to ensure the primary entrance of venous blood into the arterial circulation. More blood circulates through the systemic circulation than through the lungs. Whether the volume of blood within the lungs is sufficient to take up enough oxygen to supply the needs of the body depends on the size of the pulmonary outlet from the heart. If there is marked stenosis of the infundibulum of the right ventricle or of the pulmonary valve, the lungs may be inadequately supplied with blood.

It is only those individuals who present signs of diminished blood volume within the lungs in association with a venous-arterial shunt who are suitable for the Blalock-Taussig or Potts-Smith operations, the purpose of which is to create an artificial patent ductus connecting the aorta with the pulmonary artery. As a result, venous-arterial blood from the arterial vessel is shunted into the lungs, increasing the number of red blood cells containing reduced hemoglobin which may be exposed to the alveolar air. The most common lesion suitable for this shunting operation is the tetralogy of Fallot, in which pulmonary

TABLE I
CARDIOVASCULAR ANOMALIES

Group 1—Septa intact; ductus arteriosus and foramen ovale closed. No admixture of arterial and venous blood. Cyanosis only in presence of heart failure.
Group 2—Uncomplicated septal defect or patent ductus. Primary arterial-venous shunt. Cyanosis (1) heart failure; (2) reversal of shunt when pressure rises on right side of heart.
Group 3—Primary venous-arterial shunt—→anoxemia. Cyanosis increased by (1) pulmonary stenosis; (2) inability of oxygenated blood to enter arterial stream (transposition); (3) increased pulmonary resistance. May be absent.

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stenosis and an enlarged right ventricle are associated with a dextroposed aorta overriding a high interventricular defect.

Individuals with lesions belonging to Groups 1 and 2 are not cyanotic under normal conditions. Terminal heart failure with associated cyanosis may develop, however, as a result of the cardiac strain produced by the lesion. With simple septal defects or patent ductus there is the additional possibility of reversal of shunt leading to the appearance of cyanosis if the pressure in the pulmonary artery and right side of the heart rises under physiologic or pathologic conditions. Although terminal reversal of shunt occurs most frequently in later life, it may make its appearance in early childhood, even in infancy. Individuals with lesions included in Group 3 associated with a primary venous-arterial shunt have lowered oxygen saturation in the arterial vessels, but the anoxemia is not always of a degree sufficient to manifest itself as cyanosis, particularly in early childhood.

From the practical point of view it is important to be able to separate from the great mass of individuals with cardiovascular anomalies those who may be helped by surgical procedures. Fortunately, the lesions that may be treated surgically usually can be diagnosed by relatively simple means. Only in the relatively small group of doubtful cases need one draw upon information to be obtained by catheterization of the heart or by angiocardiography.

Anomalies of the aortic arch such as right-sided arch, double aortic arch, or anomalous vessels arising from the arch rarely present symptoms. Occasionally, however, they may produce sufficient pressure on the trachea or esophagus to result in dysphagia or respiratory distress, some-

times leading to death in infancy. The diagnosis can be established only by the roentgenologist who with the aid of barium in the esophagus and lipiodol in the trachea may be able to demonstrate constriction of the trachea and displacement of the esophagus. Only rarely is visualization by direct arteriography necessary. These anomalous vascular structures can be divided or displaced surgically to relieve pressure.

Coarctation or stenosis of the aorta is usually located distal to the origin of the left subclavian artery. If the stenosis is sufficiently marked, the entire circulation to the lower part of the body must be carried on through anastomosis between the branches of the subclavian artery and branches arising from the aorta below the site of the stricture. The pathognomonic physical finding is the presence of hypertension in the arms associated with low blood pressure readings in the legs and diminished or absent pulsations in the femoral, popliteal, and dorsalis pedis arteries. Dilated collateral vessels may be palpable and visible on the chest wall, especially in the interscapular area. Roentgenograms of the chest may show no abnormality, especially in childhood. A characteristic finding is scalloping or erosion of the lower border of the posterior ribs, produced by the presence of dilated intercostal arteries. The electrocardiogram is normal or may show some degree of left axis deviation if the left ventricle hypertrophies as a result of the hypertension. Only 25 per cent of these individuals may be expected to live a normal length of life with death due to causes unrelated to the lesion. The remainder die relatively early in life of aortic rupture, intracranial hemorrhage, bacterial endarteritis, or congestive failure.

Individuals with uncomplicated septal defects

TABLE II
CHARACTERISTIC CLINICAL FINDINGS
SIMPLE SEPTAL DEFECTS AND PATENT DUCTUS ARTERIOSUS

	Murmur	Pulse Pressure	Pulmonary Artery and Right Ventricle	Left Ventricle and Left Atrium	Aorta	Electrocardiogram
Interatrial septal defect	Systolic	Normal	Enlarged	Small	Small	Right axis deviation
Interventricular septal defect . .	Systolic	Normal	Enlarged	Rarely enlarged	Large $\pm$	Normal
Patent ductus arteriosus	Continuous	Wide	Enlarged	Not uncommonly enlarged	Large	Normal

or persistent patency of the ductus arteriosus present many features in common (Table II). Arterial blood is shunted from the left side of the heart into the pulmonary circulation so that the total blood flow within the lungs is greater than that within the systemic circulation. Because of the diversion of blood away from the peripheral circulation, there is a tendency for many of these individuals to show retarded growth and poor nutrition. Roentgenograms of the chest may show evidence of increased pulmonary blood volume as indicated by dilatation of the pulmonary artery and its branches with prominence of the conus of the right ventricle (Fig. 1).

Septal defects give rise to a systolic murmur with no diastolic component, heard best to the left of the sternum. The pulse pressure is normal. In association with an uncomplicated interatrial septal defect, only the right side of the heart and the pulmonary artery enlarge, the left ventricle and aorta remaining small. An inter-ventricular septal defect and a patent ductus arteriosus may be associated with enlargement of the left ventricle and occasionally of the left atrium together with right-sided enlargement. The electrocardiogram from an individual with interatrial septal defect usually shows some degree of right axis deviation, whereas in association with inter-ventricular septal defect there may be either no

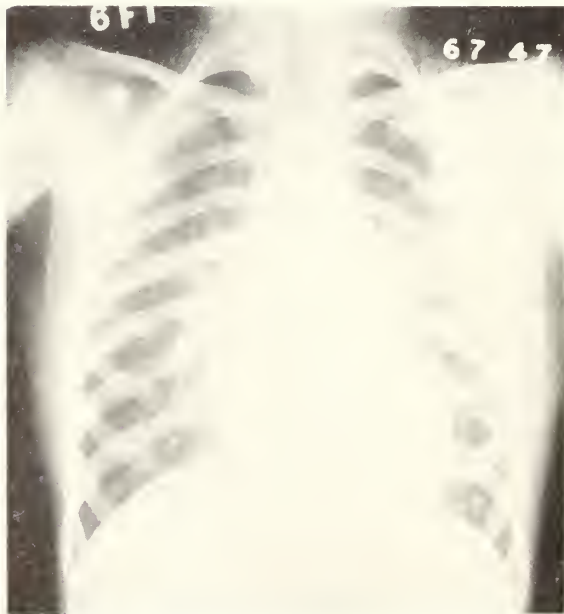


Fig. 1. Roentgenogram of chest from 11-year-old girl with patent ductus arteriosus (diagnosis proved by operation). Note evidence of increased vascularity within the lungs—prominent pulmonary artery at upper left cardiac border; increased hilar shadows with smaller vessels extending into peripheral lung fields.



Fig. 2. Roentgenogram of chest from 16-month-old girl with tetralogy of Fallot (diagnosis proved by necropsy). Small heart, transversely placed; blunt apex; no prominence in pulmonary region of heart; minimal hilar shadows; clear peripheral lung fields.

axis deviation or varying degrees of right or left axis deviation.

The finding of a continuous machinery murmur below the left clavicle is usually indicative of the presence of a patent ductus arteriosus. If uncomplicated, the electrocardiogram should be normal. Confirmatory signs, not essential to complete the diagnosis, are the presence of a wide pulse pressure (due to the leakage of blood away from the aorta) and roentgenographic evidence of enlargement of the pulmonary artery and its branches together with prominence of the conus of the right ventricle. The left side of the heart may also be enlarged in association with this lesion. Difficulty arises only in rare cases where a systolic murmur only is present and the cardiac contour suggests the possible presence of a ductus. In such cases a phonocardiogram may demonstrate a decrescendo diastolic component inaudible to the ear. Failing such confirmation, catheterization of the heart may disclose a higher percentage of oxygen in the pulmonary artery than in the right ventricle.

Differentiation between interatrial and inter-ventricular septal defects is sometimes impossible without further information such as can be obtained by catheterization of the right side of the heart. Since no adequate surgical procedure is available at present to treat these lesions, accurate diagnosis has no practical significance.

Terminal heart failure is not uncommon in all members of this group. Bacterial endocarditis may develop in association with an interventricular septal defect or patent ductus arteriosus, but

rarely occurs on the basis of an interatrial septal defect. Individuals with the latter lesion, however, have a greater than average susceptibility to rheumatic infection. Rupture of the pulmonary artery and ductus is an additional hazard in association with a patent ductus arteriosus. The entire group shares the tendency to development of sclerotic changes within the walls of the pulmonary vessels. Such changes when present in the end arteries probably contribute to the production of increased resistance within the pulmonary artery, the development of which leads to a reversal of shunt from the venous to the arterial side and the appearance of anoxemia and cyanosis.

With the aid of fluoroscopic examination, patients with the tetralogy of Fallot who may be helped surgically are not too difficult to separate from the larger group of cyanotic individuals. They cannot be differentiated by ordinary physical examination. Cyanosis and clubbing may be extreme, but are not always present at birth and in isolated cases may remain of minor degree. Many but by no means all exhibit a delay in growth and development and are poorly nourished. Dyspnea and fatigue are major factors in the inability of these individuals to engage in active exercise. Children with this lesion learn instinctively that the assumption of a squatting position relieves their respiratory distress. They are subject to attacks of increased dyspnea and cyanosis that may terminate in syncope or convulsions. Cerebral thrombosis and hemiplegia are not uncommon.

A systolic murmur or thrill may or may not be present. The second pulmonic sound may be diminished but is frequently sharply heard. It is never reduplicated. Fluoroscopic examination reveals with almost monotonous regularity certain characteristic features (Fig. 2)—a small heart, transversely placed in about 60 per cent of the cases, with blunt apex and concave pulmonary curve. In the left oblique position the aortic

window may seem unusually clear; there is increased saliency of the anterior surface resulting in a spherical contour of the heart in this position. Hilar vascular shadows may be present but do not pulsate. The lung fields are preternaturally clear because of the diminished vascularity—a “clear glass” view instead of the “frosted glass” appearance of lungs normally supplied with blood. The electrocardiogram shows marked right axis deviation. Because of the venous-arterial shunt, the arterial oxygen saturation is invariably lowered at rest and drops still further during exercise. In the presence of definite cyanosis and clubbing, the determination of the oxygen saturation is not necessary to establish the diagnosis if the fluoroscopic findings are characteristic. The circulation time is more rapid than normal. Polycythemia is not always noted in infancy and early childhood even in the presence of marked anoxemia, but is a constant finding in later life.

It is often possible to operate successfully on the cyanotic infant whose condition is sufficiently serious to lead one to believe that he will not live without surgical intervention. The difficulties of diagnosis in the neonatal period are so numerous, however, and the risk of operation so great that I doubt whether any cardiologist would be willing to refer a newborn infant to the surgeon. Most infants with operable lesions do fairly well for the first weeks or months of life when the ductus arteriosus is still patent. The newborn cyanotic infant with a cardiac anomaly who is doing poorly probably does not have a lesion that will benefit by the production of an artificial ductus. It is unwise to rush such an infant miles away to die in a distant hospital. A preferable procedure would be to send the roentgenograms and electrocardiogram (after the infant has attained the age of at least 4 weeks) to the nearest diagnostic center for opinion as to whether the child is potentially operable.



Recent Advances in Anesthesia for Thoracic Surgery

Some Uses of Procaine Hydrochloride

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FOR MANY years it was firmly believed that the intentional injection of small doses of procaine hydrochloride directly into the circulating blood stream would be followed by severe reactions. Leriche and Fontaine¹ were among the first to report, in 1935, the deliberate injection of the drug into the blood stream in an attempt to relieve intermittent claudication. Lewy,² in 1937, reported the use of procaine intravenously as a treatment of tinnitus aurium. Progress in the intravenous use of procaine remained sporadic until Lundy³ used the method in 1940 for the treatment of pruritus associated with jaundice. He said: "It is possible to obtain from two to four hours of relief of pruritus for such patients by the slow intravenous injection (requiring about two minutes) of 20 cc. of a 0.1 per cent solution of procaine hydrochloride. It is possible to assure the patients longer periods of rest by the incorporation of 1 gram of procaine hydrochloride in 1 liter of physiologic solution of sodium chloride and the intravenous administration of this solution during a period of several hours." Others followed in the use of procaine intravenously for this and many other conditions, including analgesia and anesthesia for obstetrics and surgery.

Since the introduction of the intravenous use of procaine for general anesthesia by Allen, Crossman, and Lyons⁴ in 1946, its use has become more general.

Graubard and his associates,⁵ in their work in traumatic and inflammatory conditions, have contributed greatly to the use of procaine intravenously and have shown that it is a safe hospital procedure when the administration is controlled. They have developed the "procaine unit" as the basis of their dosage. The "procaine unit" is 4 mg. of procaine per kg. of body weight administered in 20 minutes. They

use this in a concentration of 0.1 per cent in isotonic saline solution. They found that the 0.1 per cent concentration produced fewer side effects than the 0.2 per cent solution. A 70 kg. man, therefore, would receive 280 mg. of procaine hydrochloride in 20 minutes. This is administered without premedication and the patients remain ambulatory. In a series of 1954 infusions, only two patients lost momentary consciousness. These two instances were attributed to improper mixing of the solution before administration. In this series, oxygen, sedatives, or restorative drugs were not required, nor were there any cases of sensitivity or contraindications to the use of the drug.

Toxic reactions to procaine given intravenously depend on the total dose administered, the speed of the injection, and the concentration of the solution used. Large doses given rapidly may result in a sudden respiratory standstill and cardiac arrest.⁶ In these respects, toxicity of procaine given intravenously does not materially differ from the administration of procaine hydrochloride by local, infiltration, and regional nerve-block techniques.

The speed with which local anesthetic agents are metabolized in the body is important from the standpoint of toxicity. All of them are disposed of largely by the liver, but at different rates, and this rate of destruction is the deciding factor in the safety of each anesthetic agent. Procaine hydrochloride is rapidly hydrolyzed and its toxicity is relatively low. After rapid intravenous administration, hydrolysis may not be adequate to prevent accumulation of dangerous levels of procaine in the blood stream and vital tissues. It is the rapid hydrolytic destruction of procaine by the liver and by procaine esterase (into para-aminobenzoic acid and diethylamino-ethanol) that has permitted the present-day therapy with this drug.

Toxic symptoms from the intravenous use of

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procaine include pallor, apprehension, nausea, restlessness, confusion, tremors, vomiting, changes in respiratory rhythm and pulse rate, marked fall in blood pressure, convulsions, and collapse. The progression of mild to severe symptoms may be very rapid and may be followed by sudden failure of circulation and respiration. Rapid termination of the administration of procaine will usually end the progression of symptoms, and those which are present usually subside rapidly.

An occasional idiosyncrasy to the intravenous use of procaine may be present. McLachlin⁷ points out that if a rare idiosyncrasy to procaine should give rise to toxic symptoms, they may be one of two types. The first is the nervous-convulsive type. This one can usually be forestalled by closely watching the muscles of the patient. Twitching of the facial muscles and/or muscles elsewhere in the body, increased muscle tonus, and increased reflexes may be signs of impending convulsions in this type. The nervous-convulsive type can be relieved by the immediate cessation of injection of the procaine solution and, if necessary, by the administration of an intravenous barbiturate. The second type, as pointed out by McLachlin, is the respiratory-asthmatic type which may be controlled with 2 minims of a 1-1000 concentration of epinephrine hydrochloride subcutaneously.

Sensitivity to procaine should always be kept in mind and may be tested for by one or more of the following procedures:

1. Intradermal injection of 1 minim of a 2 per cent solution of procaine hydrochloride. Allow a period of 15 minutes to elapse before noting the result both locally and systemically. If the result is doubtful, a drop is instilled in one eye.
2. Conjunctival instillation.
3. Slow administration of the intravenous infusion during the initial period of injection.

Isenberger⁶ found in dogs that soluble barbiturates prevent excitement and convulsions but fail to protect against fatal respiratory and circulatory depression of large intravenous doses of procaine. He suggests that soluble barbiturates should be given slowly to patients subject to procaine convulsions and in amounts sufficient only to prevent spasmodic interference with respiratory excursions of the chest wall and diaphragm.

A number of properties of procaine hydrochloride when administered intravenously have

led to its consideration as an adjunct in anesthesia for thoracic surgery. In our hands the intravenous use of procaine in thoracic surgery is supplementary to the anesthetic agent and not used as the sole analgesic and anesthetic agent. This is important since it is believed that the convulsive effect of procaine is diminished during general anesthesia. This would seem to vary with the agent producing general anesthesia. The barbiturates provide, perhaps, the greatest amount of protection. Bittrich and Powers⁸ report that susceptibility to convulsive effects during general anesthesia with ether does not appear to be diminished. In one series, they report four cases out of seventeen receiving ether in which convulsions developed. There were probably other factors involved, namely, the disease, which was bronchiectasis, inadequate oxygenation, and inadequate removal of carbon dioxide. Convulsions also occurred in one patient who had been given sodium amytal in an intravenous infusion.

One of the prominent actions of procaine hydrochloride when administered intravenously is the production of analgesia. This is the basis for its use in a large number of cases. State and Wangenstein⁹ have reported on the mechanism of the analgesic action of procaine. They have enumerated the following possible mechanisms:

1. Potentiation of the normally secreted epinephrine content of the body. It is believed that procaine potentiates epinephrine in the blood stream. In serum sickness, for example, the circulating epinephrine is not sufficient to combat the vascular changes present. The addition of procaine hydrochloride to the blood stream will frequently bring about prompt relief from this condition.
2. Direct action of procaine on the arterioles and capillaries with widespread vasodilatation. An increase in skin temperature of the lower extremities takes place following the intravenous administration of procaine.
3. Antihistamine action. Little is known of this action. In dogs these investigators have been unable to inhibit the stimulus to gastric juice secretion of histamine.
4. Anti-acetylcholine action. Procaine depresses the response of the synapses of the sympathetic ganglia as well as the terminal efferent nerve fibers to acetylcholine. It also decreases the amount of acetylcholine liberated at these sites. In serum sickness particularly, the spreading flare about the

wheals is probably due to liberation of acetylcholine at the nerve-fiber endings at the terminal arterioles. The disappearance of the manifestations of serum sickness might logically be explained on this anti-acetylcholine action.

5. Direct action on the nerve fibers carrying pain impulses from the affected part. This is a direct anesthetic action on the nerve fibers carrying pain impulses.

It is well known that procaine hydrochloride has a special affinity for the sensory components of nerve fibers. Procaine base is liberated in the slightly alkaline body fluids and in this form is lipoid-soluble. Procaine attacks the sensory fibers first because they are smaller than motor fibers, have a larger surface area per unit of volume, and because they have a thinner myelin sheath. In this manner differential penetration of procaine in proper concentration may completely block sensation before abolishing transmission of motor impulses. Since this effect is strictly local, the anesthetic must usually be applied in such a way that an effective concentration reaches the nerve supply of the part which it is desired to affect.⁶

In the concentration that is permissible with direct intravenous injection, it would appear that only the smaller, thinner, myelinated sensory fibers will be affected. Affectation of motor fibers may require concentrations too high for safety. In cases of trauma, edema, pruritus, serum sickness, or pain, it is believed that increased capillary permeability exists which allows sufficient diffusion of procaine into the affected tissues for localized anesthesia of the nerve endings to take place.⁴

Bigelow and Harrison¹⁰ have studied the analgesic effect of procaine. They measured the cutaneous pain threshold according to the technique of Hardy, Wolff, and Goodell which uses radiant heat as the source of painful stimulation. Pain threshold determinations were made on the forehead. The procaine was injected subcutaneously in the arm, using a 2 per cent solution in amounts ranging from 5 to 40 cc. or 100 to 800 mg. They concluded that procaine has a general analgesic effect in addition to its well-known local anesthetic properties. The maximum rise in the cutaneous pain threshold attributable to the general action of the drug was about equal to that after administration of acetylsalicylic acid, that is, 35 per cent of the normal threshold value.

The duration of the procaine effect was much shorter than that of the acetylsalicylic acid. The general analgesic effect of procaine was usually more pronounced when other central effects of the drug, such as giddiness, were also evident.

The clinical application of procaine given intravenously as an analgesic agent has found many uses. Gordon¹¹ reported its use in 1943, in 10 burned patients, obtaining analgesia of the burned areas. McLachlin,⁷ in 1945, used novocain intravenously as a substitute for morphine in postoperative care and found that procaine infusions were superior to morphine in the control of pain. The usual procedure is to use 1 gram of procaine in 500-1000 cc. normal saline administered in intravenous drip, in from one to one and one-half hours. Allen et al.⁴ and Johnson and Gilbert,¹² in 1946, reported on the use of procaine in obstetrics and for ordinary surgical operations. They found that by using procaine in larger dosage, anesthesia of the central nervous system was effected which produced partial to complete unconsciousness. A 1 per cent solution in 5 per cent glucose in water was used and given at a variable rate of from 3 to 20 cc. per minute. The advantages set forth are rapid and flexible control and the absence of after-effects.

Johnson and Gilbert¹² speak of two stages or degrees of the method as used for obstetric anesthesia. In the first stage the dosage is such that normal consciousness and other functions are maintained undisturbed for indefinite periods. The infusion rate does not exceed that which is tolerated without dizziness or mental confusion, and harm or danger seems to be entirely absent. The second stage is obtained with radically higher and more rapid dosage. Subjective symptoms are ignored and are quickly broken through to reach a stage usually of semi-consciousness, sometimes of unconsciousness, in which all pain is abolished but the patient remains more or less responsible and often after a complete unconsciousness will report more or less memory of occurrences. The 1 per cent concentration is the solution used. A rather slow infusion is used for the greater part of labor to obtund but not necessarily to abolish pain. A sharply increased rate is necessary for the actual delivery and repair.

The use of procaine for surgical and obstetric anesthesia is not without danger. Allen et al.⁴ continue to use it for intravenous analgesia, but have abandoned it for general surgical anesthesia

because of the rare cases of unpredictable collapse without convulsions and without known means of prevention.

It would appear, therefore, that with the use of procaine as an analgesic agent the dangers of convulsions and unpredictable collapse without convulsions are few. However, when used in sufficient quantity to produce anesthesia, these undesirable possibilities become a real consideration.

The analgesic action of procaine is applicable in thoracic surgery because of:

1. A basal level of analgesia is produced which will permit the administration of less than the usual amount of anesthetic agent or agents.
2. Greater ease of endotracheal intubation.
3. Decreased amount of bronchospasm.
4. Less coughing efforts and reaction on the endotracheal tube during intrathoracic manipulations.
5. Shorter reaction time. With the use of lesser amounts of anesthetic agents, reflexes and consciousness return at an earlier period of time. Many of these patients will have regained consciousness before leaving the operating room.

One of the earlier uses of procaine in thoracic surgery was directed toward the control of cardiac irregularities. Pressure over the heart, mechanical stimulation of the heart, displacement of the heart from its normal position, manipulations during pulmonary resections, excision of mediastinal tumors—in fact, surgery anywhere within the thoracic cage may produce cardiac irregularity in rhythm or changes in the rate and force of contraction of the cardiac musculature. These changes may range from an occasional extrasystole to ventricular fibrillation or sudden cardiac diastolic standstill.

Many factors underlie the production of cardiac irregularities. Among these may be mentioned:

1. The emotional state of the patient.
2. Anesthetic agents.
3. The use of drugs, such as epinephrine.
4. Elicitation of reflexes, such as the vago-vagal reflex.
5. Respiratory decompensation resulting in anoxia and retention of carbon dioxide with a heightened irritability of the heart.
6. Intrathoracic manipulations necessitated by surgery.

Cardiac irregularities from any cause are serious and are to be feared because they may end in cardiac standstill or ventricular fibrillation. Procaine reduces the irritability of the automatic tissue of the heart and increases the threshold for stimuli necessary to produce fibrillation. The pacemaker may return to the normal sinus node when previously displaced, the refractory period is prolonged, and the excitability of the myocardium is diminished. Conduction in the bundle of His is retarded.^{8, 15}

It has been found that the prevention of ventricular fibrillation is more effective than the reversion to a normal rhythm after ventricular fibrillation has set in. Since ventricular fibrillation is a very serious complication, it is well, if possible, to prevent arrhythmias which may end in this complication. Intermittent injections of procaine intravenously, in 30 to 70 mg. doses,¹⁵ are better perhaps than none at all, but the method does not provide the constant protection that a continuous infusion affords. Therefore, the logical conclusion would seem to be the use of procaine intravenously in dilute concentration begun before and continued throughout surgery.

Concentration of Solution Used. At the present time we are using a 0.2 per cent concentration of procaine hydrochloride in 5 per cent glucose in distilled water. This solution is considerably less concentrated than the 1 per cent concentration used in a number of clinics. The danger of convulsive action is considerably less, but at the same time the therapeutic and desired effect may not be as readily obtainable. However, the maximum desired effect, be it vasodilatation, analgesia, or control of cardiac irregularities, is not infrequently associated with a near convulsive level of procaine in the blood stream and tissues. Bittrich and Powers⁸ report that in 5 of 17 cases arrhythmias appeared even though the rate of administration was from 65 to 100 drops per minute, using a 1 per cent solution. We believe that the use of a less concentrated solution is justified, because it is a safer procedure. The rate of administration can always be increased to control arrhythmias, if and when they do develop.

The intravenous use of procaine is valuable during any of the many intrathoracic surgical procedures. Surgery on or within the heart itself is attended with even greater danger of cardiac dysfunction than surgery elsewhere within the thorax. The use of a drug or combination of drugs which will prevent cardiac dysfunction

during cardiac surgery is, therefore, critically indicated.

One of the newer surgical procedures is mitral commissurotomy.¹³ It is one of the surgical methods in the treatment of mitral stenosis. The valve cusps in this condition appear to fuse at the commissures so that the opening becomes a shortened and narrowed slit in a thickened fibrotic plaque that surrounds the valve edges. The thickened fibrotic tissue is surrounded by a margin of fairly normal valve tissue. The operation consists essentially of cutting the plaque completely in two by two incisions at the commissures of the valve openings and extending the incision well into the normal valve tissue margin. This permits the two halves of the valve to separate freely, being hinged by soft valvular tissue at either extremity. The chordae tendinae are left intact. Increase in fluid pressure on the ventricular side forces the rigid halves of the valve together, while increase in pressure on the auricular side causes them to separate.

This surgical procedure is not only an intrathoracic procedure but intracardiac as well. Support of cardiac function and prevention of arrhythmias are of utmost importance. We should bear in mind that, at least up to the present time, patients coming to surgery have advanced mitral stenosis and are not infrequently in impending or actual cardiac failure at the time of surgery. We feel that preoperative digitalization, quinidinization, and the use of procaine intravenously during surgery are valuable in supporting cardiac function and preventing arrhythmias.

Anesthetic Technique for Mitral Commissurotomy. Premedication usually consists of the use of demerol in doses of 50 to 125 mg. with atropine sulfate 1/150 gr. one hour before surgery. The use of atropine is repeated when the patient leaves the room for the operating theater. In the operating room an intravenous infusion of 5 per cent glucose in distilled water is started in advance of anesthesia. To 500 cc. of 5 per cent glucose in distilled water, 1000 mg. of procaine hydrochloride is added. This makes a 0.2 per cent concentration. One hundred to 150 cc. is administered at the rate of 90 to 120 drops per minute to build up a level of procaine in the blood stream and tissues before surgery is started. The rate is then decreased to a range of 60 to 90 drops per minute and is varied according to the needs of the patient—increased if arrhythmias occur, decreased if bradycardia, muscle

twitchings, or other signs of toxicity occur. After the initial amount of procaine is given intravenously, the patient is anesthetized with pentothal sodium 5 per cent in doses of 250 to 500 mg. D-tubocurarine hydrochloride 6 to 15 mg. is then administered intravenously. The use of nitrous oxide and oxygen in a 50-50 combination is immediately started. When adequate relaxation appears, the patient is intubated. Anesthesia is maintained with nitrous oxide and oxygen, intermittent administration of pentothal sodium, and the continuous supplemental administration of 0.2 per cent procaine hydrochloride intravenously. A guide to the amount of procaine given is 500 mg. to the time surgery on the heart is begun and 1000 mg. by the time the operation is completed and the chest wall closed.

There have been too few cases to draw any conclusions from the use of procaine intravenously in mitral commissurotomy. Our clinical impression on its use is favorable, and we expect to report later on the progress of the anesthetic management of these cases.

Summary

1. A brief review of the progress in the use of procaine intravenously is presented. This progress, in general, has been away from the fear of direct injection of procaine hydrochloride into the circulating blood stream to its establishment under controlled conditions as a safe hospital procedure.

2. The use of procaine as an analgesic agent (0.1-0.2 per cent concentration) appears to be attended with little or no danger of convulsions or unpredictable collapse without convulsions. The use of procaine as an anesthetic agent (1 per cent concentration) is not without danger and should be limited to those experienced in its use.

3. The toxicity of procaine intravenously is discussed.

4. The analgesic action of procaine intravenously is discussed.

5. Some of the clinical applications of procaine as an analgesic agent in thoracic surgery are presented.

6. Clinical application of procaine as an agent capable of reducing cardiac irritability is discussed.

7. The operation of mitral commissurotomy and the use of procaine intravenously during this procedure are briefly presented.

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PHYSICIANS AND PHOSPHATE INSECTICIDES

During the last war, the Germans, who had concentrated their efforts on phosphorus-fluorine compounds in their intense search for lethal war gases, discovered that some of these compounds were more effective as insecticides than chemical warfare adjuncts. The compounds tetraethyl pyrophosphate, known as TEPP, hexaethyl tetraphosphate, spoken of as HETP, and O, O-diethyl O, p-nitrophenyl thiophosphate, designated E-605 by the Germans but now called parathion in the United States, were uncovered by British and American teams occupying Germany at the close of the war.

During the postwar years, these insecticides were found to be of major importance to agriculture. Of the group, parathion has been the one most extensively developed in this country. It is now being used by farmers, florists, and commercial spray operators in the form of aerosols, sprays, and dusts. So far its use by home gardeners has been discouraged.

It is highly important that the medical profession realize the widespread use of these phosphate insecticides and be informed of the toxic symptoms they cause in man. Millions of gallons of spray solutions and large quantities of dilute dust containing parathion were applied for insect and mite control during 1949. Three fatalities and an unknown number of poisonings occurred during last season. All of the fatal cases followed prolonged inhalation of parathion wettable powder or spray mist and extensive skin contact.

Parathion inactivates the cholinesterase enzymes of the blood and tissues, and, therefore, the signs and symptoms resulting from excessive absorption are primarily those of marked parasympathetic stimulation. The initial complaint is usually giddiness or headache, followed often by abdominal cramps, diarrhea, nausea, weakness, and a sense of contraction in the chest. If the cholinesterase level drops precipitously, marked signs of parasympathetic stimulation will be evidenced by hyperhidrosis, miosis, lacrimation, and salivation.

Many of the parasympathetic symptoms and signs are relieved by atropine. Doses of 1 or 2 mg. per hour

up to a daily total of 20 mg. of the drug may be required to control respiratory symptoms and to keep the patient fully atropinized. The intravenous route is best for those severely poisoned. Unfortunately, atropine does not block the muscular weakness. Artificial respiration may be necessary for many hours—clearing of the airways by suction if they are obstructed or positive pressure oxygen if pulmonary edema is present may be life-saving. Patients severely poisoned can completely recover after full atropinization and artificial respiration. Morphine should not be given. The acute emergency requiring atropine and artificial respiration may last 48 hours.

Physicians in areas where large-scale use of phosphate insecticides is prevalent should be on the alert for people who give a history of vertigo followed in two to eight hours by nausea, abdominal cramps, vomiting, diarrhea, muscular twitching, pressure in the chest, convulsions, coma, or pulmonary edema. They may be severely poisoned, and the prompt administration of atropine will block many of the parasympathetic effects.

If a person exhibits toxic symptoms from exposure to the phosphate insecticides, he should be warned against further exposure until restoration of blood and tissue cholinesterase to normal levels has taken place. Because all the phosphate insecticides inactivate cholinesterase, persons exposed to any specific one may be susceptible to any of them for a considerable period of time. Restoration of the cholinesterase level occurs slowly. Laboratory methods are available for the determination of the blood level of cholinesterase. Physicians would do well to advise their patients not to expose themselves further to the phosphate insecticides until the cholinesterase of the blood has returned to normal.

The medical profession has a great responsibility to agricultural personnel who will be using these insecticides this year—alertness on the part of physicians and hospital employees will undoubtedly cut the toll of those who would otherwise die through their own carelessness.—Editorial, *New York State Journal of Medicine*, July 1, 1950.

Malignant Lesions of the Mouth, Lips, and Jaw

HENRY P. ROYSTER, M.D.

Philadelphia, Pa.

THE MOST common cancer of the lip and oral cavity is the squamous cell carcinoma. If allowed to exist unchecked, the disease usually runs a rapidly fatal course and most of the patients will die within two or three years following its onset, after a period of intense suffering from a foul ulcerating wound. Only a few patients will present lesions of this type of several years' standing, large in extent and relatively mild in course. The large majority of patients, more than 80 per cent, receive their first treatment in the later stages of the disease, frequently not only because they do not recognize until too late that they have a serious oral lesion but often because of delay in diagnosis by a member of the medical or dental profession.

The diagnosis of oral cancer, although often arrived at by inspection with the naked eye, can be accurately made only by taking a biopsy specimen of the suspected area. This should be done in all patients with any undiagnosed lesion on the lip or in the oral cavity that has been present for one month or longer. As Dr. Hayes Martin¹ has pointed out, cancer of the mouth is more important than any other lesion with which it could be confused.

Treatment of this disease has been accomplished by two methods, either singly or in combination, namely, surgical removal (scalpel or cautery) or some form of irradiation. Each of these methods has its uses, and the modern therapist will choose from them as needed. Before its discovery and during the early days of the roentgen ray, surgical excision was the sole method of treatment. In the last four decades, and especially in the past 20 years, the development of new techniques of radiation treatment led to its widespread use in the therapy of oral cancer. Although in this country a return to the

principle of surgical excision is taking place, close cooperation between surgeon and radio-therapist is necessary to gain the advantages of both types of treatment in favor of the patient's welfare. Surgical and radiation therapy are not competitive, but rather complementary.

The therapy of oral cavity cancer may be for the local lesion alone or for metastases to the neck, when present. The primary site of the tumors, rather than the microscopic grade of malignancy, may determine the choice of the type of treatment, i.e., surgery or radiation. In the case of the lip, where the disease is more mild and results are equally good, radiation therapy has been used in this clinic. In sites surgically accessible, such as the gum, tongue, buccal mucosa, floor of the mouth, and hard and soft palate, excision is the method of election. Other areas, more remote, such as the tonsillar pillars, tonsil, pharynx and nasopharynx, are surgically inaccessible and tumors in these locations are best treated by radiation. Extensive infected growths are often irradiated to reduce the inflammation and then radically resected.

The well-known propensity of cancer of the mouth to metastasize to the cervical lymph nodes is in great part responsible for the low cure rate in the disease, as is often the case with cancer in



Fig. 1. Case 1, A. G. Rapid growth of cancer of the lower lip while under roentgen therapy. Note extension toward mucobuccal fold.

Read before the Section on Surgery at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 29, 1949.

From the Surgical Clinic of the Hospital of the University of Pennsylvania, Philadelphia.



Fig. 2. Case 1, A. G. Operative wound. Most of lower lip was excised. Double Estlander flaps from upper lip prepared for placement in lower lip.

other locations. The ineffectiveness of radiation treatment in this instance means that surgical excision must be performed or the patient is doomed, for radiation treatment of cancerous nodes metastatic from the mouth has only palliative effect. Since most patients are first seen late in the course of the disease, more often than not we must treat the cancer at its point of origin in the mouth and the metastases at the same time. By local growth the cancer may have spread widely in a horizontal direction along the mucous membrane as well as downward into the neck by continuity.

It is often possible to obtain dramatic results in widely growing tumors by radical surgical excision, not only of the local oral lesion but also of the cervical nodes, jaw bone, and other tissues, all at a single operation. Survival of many years' duration has occurred in seemingly hopeless cases, and the comfort and prolongation of life far outweigh the obvious cosmetic and functional aftermath. Radical cervical operations were first advocated in this country by Crile² in 1906 and he clearly demonstrated their benefit. Surgeons have continued to perform extensive operations with increasing success, especially since the mortality has been considerably lowered by means of the newer adjuncts to surgery. New methods in anesthesia and attention to the

maintenance of blood volume and antibiotic therapy are the important advances.

The case histories to follow illustrate some of the principles in the management of oral carcinoma.

Case Reports

CASE 1.—A. G., a 78-year-old man, had cancer of the midportion of the lower lip of two months' duration resistant to roentgen treatment. Fig. 1 shows extension of the carcinoma downward along the buccal mucosa. Radical excision was performed through the full thickness of the lip, and primary repair effected by downward rotation of two Estlander flaps from the upper lip. Three months after this operation enlarged cancerous lymph nodes appeared in each submaxillary region. A two-stage bilateral resection of the submaxillary triangles was done and the patient is well and without evidence of tumor recurrence 15 months after the first operation (Figs. 1, 2, 3, 4).

COMMENT: A rapidly growing and metastasizing lip cancer, uncontrolled by roentgen therapy, was held in check for at least 15 months by radical surgery, in three operations.

CASE 2.—B. S., a man aged 68 years, had carcinoma of the right side of the tip of the tongue, controlled by radium therapy, with bilateral cervical metastases. The patient was first known to have cancer in June, 1946. Radium treatment caused the local lesion to subside, and subsequent biopsies confirmed local cure. One year



Fig. 3. Case 1, A. G. Operative wound to show primary closure.



Fig. 4. Case 1, A. G. Three months postoperatively, before development of lymph node metastasis. Lip function excellent.

later, a large right submaxillary lymph node enlargement occurred, and shortly thereafter, other nodes on the left. In spite of a bilateral two-stage radical neck dissection, the tumor soon recurred and the patient died. Fig. 5 shows the patient one month before death.

COMMENT: The occurrence of bilateral metastases is a poor prognostic sign. This metastatic distribution is found in 20 per cent of tongue cancers and is a strong argument for performing early bilateral prophylactic neck dissections.

CASE 3.—G. M., a man aged 69 years, had a moderately late cancer of the left side of the mouth and tongue coexistent with syphilis. There were no palpable cervical lymph nodes. At the primary operation the following tissues were removed: left one-half of the tongue, anterior one-third of the tongue on the right, floor of the mouth, and submaxillary triangle tissue on the left and partially on the right. One node with metastatic cancer was found in the right submental region opposite to the side of the primary growth. Later a two-stage bilateral neck dissection was performed and the patient is now living and well without evidence of tumor two and a half years after the initial operation. In spite of the anatomic defect, the patient can eat a sufficient amount of food and he is happy and healthy.

COMMENT: In spite of the presence of a large primary tumor and cervical metastasis, the patient has a satisfactory result. The finding of a tumor in a cervical node that was not palpable before operation was evidence of the need for prophylactic neck dissection in this patient.

CASE 4.—B. C., a man aged 31 years, had on admission to the hospital a far-advanced, foul, ulcerating tumor of the symphysis of the mandible invading the

tongue, which had originated two years previously but had recurred twice following local excision. Microscopic examination of biopsy specimen disclosed it to be an adamantinoma. Secondary infection with purulent discharge was responsible for a large amount of edema of the surrounding uninvaded skin. Treatment consisted of the performance of a Stamm type of gastrostomy for feeding purposes and preliminary roentgen therapy to reduce infection and in an attempt to destroy the tumor.



Fig. 5. Case 2, B. S. End stage of neck cancer metastatic from the tongue. Patient succumbed to hemorrhage two months after the date of this photograph.

Three months after admission, radical resection was done. The excised tissue included the entire mandible, four-fifths of the tongue, and all of the neck tissues above the hyoid bone on each side. Healing occurred by granulation and epithelization. On microscopic examination of the resected specimen the pathologist was unable to find evidence of residual adamantinomatous tissue. The patient is now without recurrence of tumor eight months after operation. Plastic repair by means of large pedicle flaps is now in progress.

COMMENT: It is interesting that multiple microscopic sections through the excised mass did not show residual tumor, for adamantinomas as a group are not sensitive to radiation therapy. The preoperative radiation treatment destroyed the tumor, eradicated the spreading infection, and rendered surgical extirpation easier.

Summary

1. Treatment of cancer of the oral cavity has been discussed.
2. Primary oral cancers in surgically accessible sites are best treated by excision, with the exception of the lip.
3. Cervical metastases from the mouth can be "cured" only by radical surgical removal.
4. Four illustrative case reports are presented.

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EDITORIALS

OUR SOCIETY'S SEAL

The seal of The Medical Society of the State of Pennsylvania, which appears in the masthead of the Officers' Department of the PENNSYLVANIA MEDICAL JOURNAL, appeared first in the September, 1898 issue.

In that issue on page 211 appears the following description, with comments, of the Society's "corporate seal":

"The monogram 'A. M. A.' and the date '1847' surrounded by a circle ($1\frac{3}{4}$ inches in diameter) represents the American Medical Association and date of its organization, and the fact that it embraces in its circle the whole profession of medical men whose practice is founded upon the teaching of the regular school of medicine, embracing all branches of medical practice.

"The keystone is surrounded by a 'belt,' upon which is given the name of our state society inside the belt, and at the side of the keystone are given the date of organization and date of incorporation.

"The keystone with the monogram of the A. M. A. upon its face shows to all that our state society is in full accord with the American Medical Association, and that The Medical Society

of the State of Pennsylvania was organized in 1848 and incorporated in 1890. Our organization in 1848 gave us a professional existence; our incorporation in 1890 gave us a legal existence and added strength and influence to our state society."

COLD WAR—GROWN HOT

When, late in June, President Truman declared "I have ordered the United States air and sea forces to give the South Korean troops cover and support," he committed the United States unreservedly to the project of pushing the North Korean forces back into their own territory north of the 38th parallel. With the issuance of additional directives by the President concerning the Pacific area as a result of the continued communistic aggression from North Korea, a shooting war involving all branches of our armed services rapidly developed. This stage having been reached, the American people are preparing to play their role in defending the freedom of the Asiatic and European countries as well as our own United States from further communistic

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

aggression. To maintain this almost universal freedom may readily mean rough going ahead for most Americans over a long period of time.

An apparent early phase of the problem of meeting this international war crisis, which requires additional tanks, ships, guns, food, money, and troops, is the adequate and equitable distribution of medical manpower between the armed forces and the producers of the materiel.

During August, when few if any of the county medical societies hold meetings, the officers have been kept keenly aware of the pressing need for obtaining immediately local information essential for the allocation of medical personnel to civilian defense preparations against war-borne local disasters and to the selection of medical officers under the direction of the Procurement and Assignment Committees.

The members of the Board of Trustees and Councilors and other officers of The Medical Society of the State of Pennsylvania have been diligent. There have been conferences between State Society committees and Federal government representatives and officials of the American Medical Association. State and county medical society committees on civilian defense and procurement and assignment of medical officers have been at work.

From the profession's viewpoint, the crying and yet most disturbing need has been the urgent demand by the Army for medical personnel. Pennsylvania doctors who served from two to five years in World War II have been alerted for duty in September and October. These men, some of whom spent many months overseas, will leave behind them not only their families of varying size but a medical practice established or re-established since their release from active military service four or five years ago.

The chief aim of the procurement and assignment committees has been to supply medical manpower for the Army. They have recommended for prompt induction into the Army the younger medical men who have had little or no previous military service, especially those whose service consisted of living in barracks under Army pay and direction while receiving their medical college training at government expense. These present committees, following up the five-year effort of the American Medical Association to bring about flexibility in the military employment of medical personnel, are striving to have recognized the need where it is greatest, whether it be for service with the troops or for civilian

defense, and to have medical men assigned to work which calls for the application of their professional skill.

Obviously, success in these important movements on the part of the members of the medical profession, regardless of age or location, depends upon realistic cooperation by the entire profession. All must be prepared to accept any change in plans justified by increasing military needs or by preparations for civilian defense.

NUTRITION IN GASTRO-INTESTINAL DISEASES

With Particular Reference to Duodenal Ulcer and Ulcerative Colitis

(EDITOR'S NOTE: This is the sixth of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania.)

The objective in the dietary management of uncomplicated duodenal ulcer should have as its basis the control of abnormal gastric physiology. This abnormal physiology consists of gastric hypersecretion, hypermotility, and hypertonus. To correct such abnormalities, foods which neutralize free hydrochloric acid, depress gastric motility, and are non-irritating should be prescribed.

The ideal dietary regimen consists of bland foods administered at frequent intervals and in moderate amounts. It is devoid of roughage so as to lessen mechanical irritation of the ulcer. The individual feedings are not excessive in amount in order to avoid undue distention of the stomach and stimulation of excessive peristalsis. Milk comprises a large proportion of the dietary: it is an excellent bland food because of its relatively high acid-combining power. It is capable of neutralizing its own volume of 0.3 per cent hydrochloric acid. Various proportions of cream can be combined with the milk, depending on the caloric intake desired. The fat of the cream is especially beneficial because its entrance into the upper small intestine serves to suppress secretion of free hydrochloric acid.

The rate of gastric emptying in uncomplicated duodenal ulcer is frequently rapid. Unless the dietary contains foods which are capable of prolonging emptying time, the ulcer site may be exposed to acid gastric juice during the intervals between feedings. This results in relatively brief relief of pain and in continued activity of the

ulcer. Gastric emptying may be delayed by dietary means by one of two methods: (1) by including a liberal proportion of bland fat such as contained in cream and butter (a palatable vegetable oil may be substituted in individuals with arteriosclerosis and high serum concentration of cholesterol), or (2) by ingesting bland protein and carbohydrate foods, such as protein hydrolysate and dextrimaltose, in hypertonic concentrations. Hypertonic solutions remain in the stomach until they are diluted sufficiently for entry into the small intestine.

Sufficiency of protein is desirable to insure a positive nitrogen balance and proper healing of diseased tissue. In some instances of ulcer, especially those with complications which tend to deplete protein stores, the dietary may have been restricted to milk and bland foods, and the amount of protein may have been insufficient to attain a positive nitrogen balance. When such is the case, the nitrogen intake may be increased by adding a crude casein preparation to the milk or by substituting a 30 per cent protein hydrolysate solution for the usual interval feeding.

Other foodstuffs such as carbohydrate—especially starches which have relatively little effect on gastric secretion—should comprise a liberal proportion of the dietary in order to supply calories and spare protein. Citrus fruit juices are avoided because they may irritate an inflamed and congested gastric or duodenal mucosa. Vitamin C should be administered in order to avoid the development of scurvy with its hemorrhagic tendencies. Caffeine-containing beverages are also omitted from the dietary because they stimulate the secretion of gastric juice.

The nutritional problem in chronic ulcerative colitis is somewhat different from that in uncomplicated duodenal ulcer. The average patient has lost his appetite, is underweight, has varying degrees of vitamin deficiency, and is anemic, hypoproteinemic, and dehydrated. The basic nutritional aims are: (1) to provide rest for the inflamed bowel and (2) to supply an adequate amount and type of "building stones" for the repair of a large area of tissue destruction as well as to replace depleted body stores. One usually attempts to accomplish these aims by administering a high caloric, high protein, high carbohydrate, low residue diet, adequate in minerals and vitamins and free of gas-forming, allergenic, and irritating foods.

The foods of the usual diet are not satisfactory in the management of idiopathic ulcerative colitis

during the stage of acute inflammation for various reasons. The average patient has already become malnourished with such a diet available to him and is in negative nitrogen balance. Even if consumed in adequate amounts, the protein fraction of the usual diet is poorly absorbed. This has been demonstrated by studies of the nitrogen content of the ileal discharges. Also, on the basis of physiologic experiments, it is clear that the residue of the ordinary diet as it passes into the colon induces active peristalsis, even mass movements. The inflamed colon, furthermore, is irritable and hypersusceptible to the stimulus of its content, and it will heal more promptly if irritation, such as results from food that gives rise to bulky residue, is prevented. Another factor which must be taken into consideration is that of allergy. Sometimes ulcerative colitis patients develop an allergy to certain foods which are common items in their dietary, such as milk, eggs, and wheat products. The failure to omit such foods may prolong the course of the disease.

When ordinary foods are omitted or restricted for one reason or another, adequate alimentation often is difficult and, at times, impossible. When faced with a seemingly impossible situation from the standpoint of supplying sufficient calories and protein, adequate nutrition may be achieved by a regimen consisting of a solution of equal parts of a protein hydrolysate preparation and a less readily fermentable carbohydrate such as dextrimaltose. Such feeding is advantageous to an ulcerative colitis patient for the following reasons: (1) a large caloric intake is readily possible; (2) one-half of the caloric intake consists of protein, 300 to 400 grams, this being the primary need; (3) the protein is in a readily assimilable form; (4) its absorption also tends to promote a positive nitrogen balance; (5) the hydrolysate gives rise to a negligible residue, consequently the diseased colon is afforded more rest; and (6) the mixture is hypo-allergenic. Such alimentation meets all of the requirements of the basic nutritional aims except for inadequacy in iron and vitamins (including vitamin K), which must be supplemented. Following disappearance of subjective and subsidence of objective evidence of activity of the disease, a dietary consisting of ordinary foods possessing the characteristics outlined previously is gradually administered.

THOMAS E. MACHELLA, M.D.

Graduate Education Institute to Award Certificates at One Hundredth Annual Session

373 Society Members to Be Honored

During World War II and immediately thereafter, medical postgraduate courses were at a minimum. Teachers and practitioners were in the service or carrying a double load at home.

Many recent advances in medical science gave evidence of the need for postgraduate instruction. Rural areas were particularly in need of facilities. The travel distances and time involved in going to medical centers were prohibitive and the time involved was unavailable.

In 1947 the Commission on Graduate Education determined that it should provide the busy general practitioner with practical instruction at the postgraduate level, reasonably close to his home and with a minimum expenditure of time and money. Thus the Graduate Education Institute was born.

With a budgetary allotment from the Board of Trustees, the commission secured the services of the faculties of the medical schools, rented auditorium facilities in six centers, and arranged a general refresher course for practitioners on a variety of subjects. Appropriate literature was prepared and distributed to the members. Much to the pleasure of everyone, the venture was a success. Registrations were beyond all expectations and the Graduate Education Institute was in business.

Ten courses presented once each week, for five weeks in the fall of 1947 and five weeks in the spring of 1948, completed the first year's program.

The second year, four new centers were added and registrants continued upward to 1100. The third year another new center was added and registrations leveled off to 900. The three-year course was completed in the spring of 1950.

To honor those who were faithful in attendance, the commission will present certificates to all who attended 70 per cent of the sessions over a three-year period. Three hundred and seventy-three physicians will be so honored at the one hundredth annual session of the MSSP, this to be preceded by an appropriate address by Wallace M. Yater, M.D., of Washington, D. C., on the subject of "Keeping Abreast of Medical Progress."

The certificates will be signed by the deans of the seven medical schools in the State, the president, the secretary-treasurer, the chairman of the Board of Trustees, and the chairman of the Commission on Graduate Education of The Medical Society of the State of Pennsylvania. An attractive booklet containing a philosophy of the practice of medicine, entitled "The Care of the Patient" by Francis W. Peabody, M.D., will also be presented with the certificates.

The proof of the success of this venture in postgraduate training is the fact that a new five-year program has been announced. With the beginning date of the course a month away, registrations now number over 400. Even with the possibility of international warfare looming on the horizon, expectations are high for another successful program.

OFFICIAL TRANSACTIONS

One Hundredth Annual Session

REPORTS OF OFFICERS

REPORT OF SECRETARY-TREASURER

To the President and House of Delegates:

Financial Statement

The financial portion of the secretary-treasurer's report could not be completed in time for publication in the August JOURNAL since the Society's fiscal year does not end until September 30. Attention is called to this in the report of the secretary-treasurer in the August JOURNAL.

GENERAL FUND

Balance on hand Sept. 30, 1949 \$70,437.44

RECEIPTS

Allotment from dues (1949-1950) ..	\$207,159.50
JOURNAL	45,514.52
Annual session	22,998.50
Graduate Education Committee	26,740.00
Refund AMA, Public Relations Com.	3,127.41
Rent, 226 State Street	1,500.00
Proceeds U. S. Savings Bonds in social security tax reserve fund ..	7,464.03
Sale of used equipment	187.50
Library	138.29
Second Councilor District meeting ..	219.00
1949 Rosters	53.00
History	68.50
Postage remittance, letter-bulletin ser- vice	80.00
Refunds and miscellaneous	312.42

Total administrative receipts	\$315,562.67
Transfer—from Medical Benevolence Fund, payment of check No. 1335 to Benevolence Committee for payments to beneficiaries	16,204.07
Withheld from employees' salaries for pension fund and Federal old age security	1,524.16
	\$403,728.34

DISBURSEMENTS

JOURNAL (printing, mailing, salary of editorial as- sistant, and 65% salary managing editor)	\$55,843.55
Executive secretary and Harrisburg office staff, salaries *	26,979.55
Secretary-treasurer-editor and Pittsburgh office staff, salaries *	18,096.00
Annual session (including 35% salary convention manager)	20,352.81
Library	4,713.36
Secretaries-editors conference	4,700.00
226-230 State St., taxes, repairs, upkeep	6,036.83
Officers' travel expense	4,578.58
Employees' pension fund, 1950 premium	3,473.68
Office equipment and furnishings	3,883.56
Stationery, supplies, miscellaneous printing †	2,846.42
Travel expenses, AMA delegates (6)	2,732.96
Telephone service and toll calls †	2,185.27
Councilor district meetings	2,160.56

* Does not include salaries connected with functioning of Committees on Graduate Education, Public Health Legislation, and Public Relations. Salaries paid total \$107,835, from which \$11,243 was withheld for income taxes.

† These expenditures provide facilities for routine office procedures and are freely used by the various committees.

Reimbursement petty cash funds—

Harrisburg office	\$2,083.35
Pittsburgh office	570.04

\$2,653.39

Rent	1,987.20
Federal social security taxes	1,378.68
Postage	1,305.00
Special printing (1949 Roster, triplicate receipt hooks, letter to membership)	1,298.65
Contribution to ACES	1,000.00
Pennsylvania unemployment taxes	886.92
Insurance premiums, officers' bonds, workmen's compensation liability insurance	585.76
300 copies "Keystones" Survey	675.00
Legal counsel, retaining fee	500.00
Annual audit of accounts	450.00
Dues—Pa. & Ilhg. Chambers of Commerce, Conf. State Socy. Officers, Pa. Health Council	200.00
World Medical Association, contribution	100.00
Maintenance of office equipment	192.95
Federal unemployment excise tax	199.69
MSSP History	64.56
Miscellaneous	161.25

Committees:

Public Relations	\$53,652.38
Graduate Education	44,350.13
Public Health Legislation	20,342.12
Cancer	1,478.17
Appendicitis	1,193.15
Preventive Med. and Public Health	832.27
Diabetes	653.34
Disaster Emerg. Med. Service	457.50
Public Assistance Subadvisory	378.46
Rheumatic Fever	307.06
Physical Med. and Rehabilitation	278.08
Tuberculosis	252.16
Industrial Health	234.17
Rural Medical Care	184.00
Laboratory	164.26
Syphilis and Venereal Diseases	125.12
Miscellaneous committees (average \$96 each)	863.90

125,746.27

Total administrative expenditures \$297,968.45

OTHER DISBURSEMENTS

Medical benevolence (see also Receipts)	16,204.07
Total	\$314,172.52
Balance on hand Sept. 30, 1950	\$89,555.82

MEDICAL DEFENSE FUND

Balance on hand Sept. 30, 1949 \$17,793.61

RECEIPTS

Interest on deposits	\$66.35
Interest on investments	187.50
	253.85
	\$18,047.46

DISBURSEMENTS

Withdrawn for purchase of U. S. Savings bonds for Medical Defense Fund	\$15,000.00
Balance on hand Sept. 30, 1950	\$3,047.46

ENDOWMENT FUND

Balance on hand Sept. 30, 1949 \$3,315.27

RECEIPTS

Interest on deposits	\$33.12
Interest on investments	930.00
	963.12

DISBURSEMENTS—None

Balance on hand Sept. 30, 1950 \$4,278.39

EDUCATIONAL FUND

Balance on hand Sept. 30, 1949 \$1,151.80

RECEIPTS

Allotment from 1950 dues (\$2.00 per capita) \$20,791.00
Interest on deposits 69.71
Interest on investments 262.50
21,123.21

\$22,275.01

DISBURSEMENTS

Withdrawn for purchase of U. S. Savings Bonds for Educational Fund \$20,000.00

Balance on hand Sept. 30, 1950 \$2,275.01

BUILDING FUND ACCOUNT

Balance on hand Sept. 30, 1949 \$6,148.39

RECEIPTS

Proceeds U. S. Treasury Certificates \$50,053.22
Proceeds U. S. Savings Bonds in Medical Defense Fund (loaned) .. 35,335.00
Interest on investments 625.00
86,013.22
\$92,161.61

DISBURSEMENTS

For building alterations—226-230 State St. to August 5 \$75,156.14

Balance on hand Sept. 30, 1950 \$17,005.47

MEDICAL BENEVOLENCE FUND

Balance on hand Sept. 30, 1949 \$2,247.08

RECEIPTS

Allotment from 1950 dues (\$1.00 per capita) \$10,395.50
Interest on deposits 80.30
Interest on investments 5,750.00
Contributions 10,373.77
26,599.57
\$28,846.65

DISBURSEMENTS

Withdrawn for purchase of U. S. Savings Bonds \$10,000.00
Transferred to checking account in payment of check No. 1335 * 16,204.07
26,204.07

Balance on hand Sept. 30, 1950 \$2,642.58

CONTRIBUTIONS FROM WOMAN'S AUXILIARIES AND OTHERS

State Society	\$500.00	Cumberland	\$42.00
Allegheny	1,764.37	Dauphin	260.00
Armstrong	60.00	Delaware	155.00
Beaver	155.00	Delaware County	
Berks	345.00	Medical Club ..	25.00
Blair	150.00	Elk	39.00
Bradford	70.40	Erie	250.00
Bucks	150.00	Fayette	150.00
Butler	50.00	Franklin	80.00
Cambria	175.00	Greene	110.00
Carbon	57.00	Huntingdon	50.00
Chester	150.00	Indiana	125.00
Centre	60.00	Lackawanna	465.00
Clearfield	50.00	Lancaster	200.00
Clinton	75.00	Lawrence	77.00
Columbia	26.00	Lebanon	155.00
Crawford	50.00	Lehigh	640.00

* This amount is the total of contributions and interest on investments and deposits which is transferred to the Benevolence Committee's account for disbursement to beneficiaries. See also report of Medical Benevolence Committee.

Luzerne	\$355.00	North of the Mt. Branch	\$39.00
Lycoming	300.00	Somerset	60.00
Mercer	165.00	Tioga	50.00
Mifflin	50.00	Venango	160.00
Montgomery	1,010.00	Warren	75.00
Montour	50.00	Washington	125.00
Northampton	300.00	Wayne-Pike	20.00
Northumberland ..	60.00	Westmoreland ..	220.00
Perry, Juniata, and Mifflin	10.00	New Kensington Branch	100.00
Philadelphia	150.00	York	100.00
Potter	9.00		
Schuylkill	130.00	Total	\$10,248.77

Additional contributions:

"A member," Philadelphia County (\$10)
Dr. Charles Wm. Smith, Dauphin County (\$10)
Dr. Thomas H. Low, Northampton County (\$5)
Dr. Wm. A. Finady, Northampton County (\$100) \$125.00

Total contributions \$10,373.77

INVESTMENT OF SPECIAL FUNDS

(Maturity Valuation Listed)

MEDICAL DEFENSE FUND

United States Savings Bonds, Defense Series "F" as follows:

Due 1953—No. X4068F, registered \$10,000.00
1954—Nos. V36387F-36388F-69922F, registered 15,000.00
Due 1954—Nos. M143123F-143124F-240481F-249482F-442945-6 6,000.00
Nos. C192362F-274873-4-5-6F-596704F 600.00
D243976F 500.00

United States Savings Bonds, Series "G," as follows:

Due 1961—Nos. V1017060-52 15,000.00

Total \$47,100.00

U. S. Savings Bonds of maturity value \$41,500 in the Medical Defense Fund were sold at \$35,335 to provide a loan in the latter amount for the Society's Building Fund account. A demand note at 3 per cent for that amount payable in \$5,000 installments has been placed in the Safekeeping Depository of the Peoples First National Bank and Trust Company (see report of the chairman of the Board of Trustees on page 853 of the August PENNSYLVANIA MEDICAL JOURNAL).

MEDICAL BENEVOLENCE FUND

United States Treasury Bonds, due

1972-67, 2½%, No. 196502B \$10,000.00
United States Treasury Savings Bonds, Series "G," due 1958, No. X690449G 10,000.00

United States Savings Bonds, Defense Series "G," as follows:

Due 1953—No. X4156G, registered 10,000.00
Due 1954—Nos. X159758G-173579G-173580G, registered 30,000.00
Nos. V83721G-121809G-128860G-178894G-186812G-187363G-187364G 35,000.00
Nos. M119553-54G-683545-6-7-683548G 6,000.00
Nos. D155217G-231345G 1,000.00
Nos. C897766G-67G-928209G-10G-11G-935220G-935221G 700.00

Due 1955—Nos. X246103G-246104G-246339G, registered 30,000.00
Nos. M1290745G-6G ... 2,000.00
Nos. C1109842G-3G-1110673G 300.00
Due 1956—No. X504348G, registered 10,000.00
Due 1960—No. V842499 5,000.00
No. X875960 10,000.00

Comparative Financial Statement

Assets	Sept. 30 1950	Sept. 30 1949	Increase Decrease *
<i>Current Assets</i>			
<i>Cash</i>			
Cash in banks (checking and savings accounts)	\$118,804.74	\$101,093.60	\$17,711.14
Petty cash—Pittsburgh	200.00	200.00	.....
Petty cash—Harrisburg	1,200.00	1,000.00	200.00
<i>Total cash on hand and in banks</i>	<u>\$120,204.74</u>	<u>\$102,293.60</u>	<u>\$17,911.14</u>
<i>Investments</i>			
Medical Benevolence Fund			
Schedule A-1	\$255,000.00	\$242,500.00	\$12,500.00
Medical Defense Fund			
Schedule A-1	38,754.00	54,464.00	15,710.00*
Endowment Fund			
Schedule A-1	39,705.44	39,705.44	.....
Social Security Tax Reserve Fund			
Schedule A-1 .....	.....	7,020.88	7,020.88*
Educational Fund			
Schedule A-1	41,000.00	20,029.32	20,970.68
Building Fund			
Schedule A-1 .....	.....	50,014.76	50,014.76*
<i>Total investments</i>	<u>\$374,459.44</u>	<u>\$413,734.40</u>	<u>\$39,274.96*</u>
<i>Total current assets</i>	<u>\$494,664.18</u>	<u>\$516,028.00</u>	<u>\$21,363.82*</u>
<i>Fixed Assets</i>			
Land and buildings, Harrisburg	\$161,662.80	\$86,506.66	\$75,156.14
Furniture and fixtures, Harrisburg	16,133.32	12,855.78	3,277.54
Furniture and fixtures, Pittsburgh	3,054.12	2,448.10	606.02
<i>Total fixed assets</i>	<u>\$180,850.24</u>	<u>\$101,810.54</u>	<u>\$79,039.70</u>
<i>Total assets</i>	<u>\$675,514.42</u>	<u>\$617,838.54</u>	<u>\$57,675.88</u>
<i>Liabilities—None</i>			
<i>Surplus</i>			
Assets in excess of liabilities			
Schedule A-2	\$675,514.42	\$617,838.54	\$57,675.88
<i>Total liabilities and surplus</i>	<u>\$675,514.42</u>	<u>\$617,838.54</u>	<u>\$57,675.88</u>

Due 1961—Nos. 906420-21, V906401G, 906432-33, 906444, 906483, 929701, V906705G, V942324G, V942266G-67-68. 69-70G	75,000.00
Due 1962—Nos. V1056896G-97G ..	10,000.00
No. X1171052G	10,000.00
Total	\$255,000.00

ENDOWMENT FUND

United States Treasury Bonds, due 1963-68, Nos. 88352C-53D-54E-55F- 56G	\$5,000.00
United States Savings Bonds, Series "G," as follows:	
Due 1953—No. X893639	10,000.00
No. V911639	5,000.00
Nos. M480339-340	2,000.00
Due 1954—No. V911640	5,000.00
Nos. M6480341-342	2,000.00
No. D2932835	500.00
Nos. C5210298-299	200.00
Due 1961—Nos. V942265G, 906419	10,000.00
Total	\$39,700.00

EDUCATIONAL FUND

United States Treasury Notes, Series E-1951, 1¼%:	
Due 1951—Nos. 39492-93	\$20,000.00
United States Savings Bonds, Series G:	
Due 1962—No. M7358879G	1,000.00
Nos. X1171053G-54G ..	20,000.00
Total	\$41,000.00

Total maturity value of investments	\$382,800.00
Total cash balances:	
in checking account	\$89,555.82
in savings accounts—medical defense, medical benevolence, endowment, educational fund ...	\$12,243.44
in building fund account	\$17,005.47

The Society holds title to headquarters properties in Harrisburg.

Respectfully submitted,

WALTER F. DONALDSON,
Secretary-Treasurer.

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

To the President and House of Delegates:

The Medical Society of the State of Pennsylvania was represented at the 1950 Session of the House of Delegates of the American Medical Association by its eleven elected delegates. The state delegation assembled on Sunday evening, prior to the opening session of the House of Delegates, in order to organize, discuss matters referred to it, and discuss its action on matters to be brought before the House of Delegates.

At this first caucus, both the chairman, Dr. Appel, and the secretary, Dr. Whitehill, were re-elected. The first matter discussed was a resolution from the McKean County (Pa.) Medical Society advocating a re-

turn to county medical societies of a portion of the AMA dues for local public relations use. This resolution was referred to the delegation by the Board of MSSP. The delegation decided against introducing this resolution into the House of Delegates inasmuch as the plan of the Education Campaign Committee for 1950-51 included advertising in local papers and over local radio stations, which was the apparent purpose of this proposed refund.

The second matter referred to the delegation by the Board of Trustees of MSSP was a resolution from the Pennsylvania Radiological Society endorsing the original "Hess Report" and urging its strict enforcement. Since the original Hess Report was reconsidered at the Washington session of the House of Delegates of the AMA and referred back to the "Hess Committee" for rewording in order to comply with legal interpretation, and since there would therefore be a new "Hess Report" introduced into the House of Delegates at this session of the House, your delegation voted to table this resolution and await developments in the House, recognizing the intent of the resolution of the Pennsylvania Radiological Society in its consideration of the new "Hess Report."

The Board of Trustees of MSSP referred to your delegation a communication from the New Jersey State Medical Society requesting our study and possible co-sponsorship of an attached "proposal of the Medical Society of New Jersey for a National Health and Medical Care Program." Your delegation voted in caucus not to co-sponsor or endorse the "New Jersey Plan."

At the opening session of the House of Delegates, the Speaker of the House, Dr. Francis F. Borzell of the Pennsylvania delegation, announced his committee appointments. In the absence of the vice-speaker, Dr. Reuling, Dr. Borzell asked the permission of the House to appoint Dr. William Bates of Pennsylvania as vice-speaker pro tem. This was confirmed. Dr. Borzell then appointed Dr. James L. Whitehill of Pennsylvania to the Reference Committee on Reports of the Board of Trustees and Secretary, Dr. Harold B. Gardner of Pennsylvania to the Reference Committee on Medical Education, Dr. William L. Estes, Jr., of Pennsylvania to the Special Committee on Publicity, and Dr. James Z. Appel of Pennsylvania to the Reference Committee on Industrial Health.

The first order of business was the election of the recipient for the distinguished Service Award. Dr. Evarts A. Graham, of St. Louis, was elected on the first ballot.

There were several items worthy of mention in the report of the Board of Trustees. First, the Board of Trustees clarified who shall be required to pay AMA dues. The county society shall be the sole judge as to when the payment of AMA dues is a hardship and should be remitted. However, the dues to the AMA will not be remitted unless state and county dues likewise are remitted. A person in actual intern and residency training not to exceed five years after his graduation from medical school will be exempted provided his county and state dues are exempted. Dues for 1951 shall be \$25.00, if he joins prior to July 1. If he joins after July 1, they shall be \$12.50. A member who moves from one state or county to another need not pay his dues in the state or county to which he moves

if he has already paid them in the state or county of his original residence. In order to pay the costs of collecting AMA dues by state societies, they will be reimbursed at the rate of 1 per cent of the amount of dues collected. This shall be retroactive to 1950.

Numerous resolutions were introduced concerning the method of collecting dues, including subscription to the *AMA Journal* in membership dues and abolishing the classification of Fellowship. All these resolutions were disapproved except that which included subscription to the *AMA Journal* in membership dues. Adjustment of fellowship dues was deferred to the Interim Session of the House of Delegates.

The report of the Committee on Displaced Physicians which was first presented to the House at the Washington session and on which action was deferred at that time was adopted by this House. This report urged state boards of medical education and licensure to seek ways and means of facilitating the licensing of displaced physicians so they might immigrate into this country.

The Committee on General Practice noted progress in the recognition of the general practitioner by development in many hospitals of sections on general practice. The advantages of experience as a general practitioner prior to specialization were brought out and called to the attention of specialty boards. In this connection, several resolutions were submitted to the House recommending that specialty boards make this a mandatory prerequisite to specialty residencies. These resolutions were not adopted.

In the report of the Council on National Emergency Medical Service, authority was given to send letters of commendation to several governmental persons and agencies for their performances the past year. This unexpectedly brought forth some criticism in the case of commendations for the Secretary of Defense. His wisdom in closing several military hospitals was so seriously questioned that the House rejected commending the Secretary of Defense. Since a Pennsylvania delegate, Dr. Klump, took an active and effective part in this debate, Dr. Sargent of the Council requested an opportunity to speak to the delegation in caucus. This was granted. The state delegates heard Dr. Sargent and entered into a general discussion with him. However, they voted to endorse Dr. Klump's action and refused to move before the House that the matter be reconsidered.

General principles for the establishment of a Student American Medical Association were presented and approved. It was urged that the formation of such organizations in medical schools be expedited as rapidly as possible.

Related to this was the report of the Council on Medical Education and Hospitals to study the Association of Interns and Medical Students. This committee recommended that the AMA should not endorse this organization inasmuch as its past actions indicate that it might be suspected of leftist tendencies. The committee report was approved.

The Board of Trustees distributed two very interesting reports of two committees of the AMA sent to England to study conditions there. The one committee studied the effect of the National Health Service on the practice of medicine. The other committee studied its effect on medical education in Great Britain. These re-

ports or a summary of them will appear in the *Journal of the AMA*.

The report of the Committee on Hospitals and the Practice of Medicine, commonly called the Hess Report, created much controversy. The reference committee acting on this report held a huge and lengthy hearing. In its report to the House of Delegates, the reference committee made extensive deletions and additions to the report. To most members of the House this report of the reference committee was most confusing. The chairman of your delegation will attempt to briefly explain the present status of the adopted report.

First, the report stated as a premise that "as a matter of law the corporate practice of medicine is illegal in most states. In almost all instances the classical example given by the courts of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a professional man and then sells his service to the public on a fee basis for the profit of the corporation." Portions of the Code of Medical Ethics are quoted to explain this premise. The Hess Report continues with pointing out how hospitalization and medical insurance plans have tended to confuse the issue so far as the payment for radiologic, anesthesiologic, pathologic, and physiotherapy services is concerned. The report quotes from a previous action of the House of Delegates of the AMA that "if hospital service is limited to include only hospital room accommodations, such as bed, board, operating room, medicines, surgical dressings, and general hospital care, the distinction between general hospital care and medical service will be clear." The Hess Committee therefore recommends "that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services."

The report continues: "In addition, it also believes that the commercial insurance companies should be requested to write their policies with this principle of the separation of hospital and medical services in mind." The Hess Committee recommends that there should be a closer relationship developed between the professional staff of a hospital and its directing boards so that the problems of finances and professional needs may be mutually better understood; and in this respect there should be no distinction between surgeons, internists, radiologists, anesthesiologists, etc., as members of the professional staff. If such close relationship is developed, the committee believes that "in the event of a controversy between physician and physician, or physician and

hospital management, on these problems, since local conditions must be taken into consideration, these problems can be resolved so far as possible at the local level." If this fails, then in succession the county and then the state society can be called on to help negotiate the difficulties. If these fail, then appeal can be made to the Judicial Council of the AMA for assistance as provided in the By-Laws of the AMA. In order to accomplish this, the Hess Committee recommends that special committees on hospital relations be appointed at the local, county, and state levels.

The reference committee deleted the entire portion of the Hess Report that incorporated the so-called McKittridge Report. It also outlined a procedure that might be followed in case a hospital should employ a physician under such conditions which are considered in violation of the aforesaid principles. According to this outline, the Judicial Council is authorized by the By-Laws, page 31, to investigate general professional conditions. If the Judicial Council finds sufficient evidence, it should direct an appeal to the Council on Medical Education and Hospitals to show cause as to why said hospital should not be dropped from the approved list as advocating unethical and perhaps illegal practice of medicine.

The report of this reference committee was adopted.

The Tennessee resolution on veterans' care was again tabled by the House.

A resolution approving the testing of urine for sugar by patients was approved.

A resolution encouraging constituent and county medical societies to cease discriminating on the grounds of race for membership in their societies was approved.

After a rather warm debate, the so-called New Jersey Plan was not adopted, but was referred to the Board of Trustees for consideration and guidance.

Dr. John W. Cline of San Francisco, Calif., was elected without opposition as president-elect of the AMA. In his speech of acceptance he delivered a very forceful address, in which he pointed out that "we are fighting for the freedom and the medical welfare of the people of our country. Our cause is estimable, our position is strong . . . the active and vigorous participation of this group (the medical profession) is essential and must be obtained at the local level."

More than 170 pieces of legislation were acted upon. The above is a very brief outline of the more important ones.

Respectfully submitted,

JAMES L. WHITEHILL, *Secretary*

JAMES Z. APPEL, *Chairman*

You Save \$15.00 ! !

When you attend the Annual Meeting, please plan to spend a generous amount of time in the exhibits . . . both the scientific and the technical. The revenue derived from the technical exhibits saves you a \$15.00 registration fee. It will assist us in our relations with the exhibitors if you will *register in at least ten booths* for samples and literature. Also, spend time in the scientific exhibits. They have been prepared at considerable expense, and are made available for the education of those in attendance at our meeting.

Your cooperation will give us the opportunity of planning an outstanding meeting for you in 1951.

REFERRAL OF 1950 REPORTS BY SPEAKER OF HOUSE OF DELEGATES

To the Reference Committee on Reports of Officers—

Herman A. Fischer, Jr., Wilkes-Barre, *chairman*

Reports of:

Secretary-Treasurer
Chairman of the Board of Trustees and Councilors
Editor
12 Individual Councilors

To the Reference Committee on Reports of Standing Committees—

Russell B. Roth, Erie, *chairman*

Reports of:

Committee on Medical Economics
Committee on Public Health Legislation
Committee on Public Relations
Committee on Archives
Committee on Educational Fund
Committee on Necrology
Committee on Medical Benevolence
Advisory Committee to Woman's Auxiliary
Committee on Psychiatric Services to Criminal Courts
Committee on Rural Medical Service
Committee on Workmen's Compensation Laws
Committee on Telephone Directory Classification

To the Reference Committee on Reports of Commissions—

Joseph J. Toland, Jr., Philadelphia, *chairman*

Reports of:

Commission on Cancer
Commission on Child Health
Commission on Conservation of Vision

Commission on Deafness Prevention and Amelioration

Commission on Defense of Medical Research

Commission on Diabetes

Commission on Graduate Education

Commission on Industrial Health and Hygiene

State Healing Arts Advisory Committee

Commission on Laboratories

Commission on Nutrition

Commission on Physical Medicine and Rehabilitation

Advisory Committee to Pennsylvania Board for Vocational Education

To the Reference Committee on Scientific Business—

Stanley D. Conklin, Sayre, *chairman*

Reports of:

Commission on Maternal Welfare
Commission to Study Control of Rheumatic Fever
Commission on the Control of Syphilis and Venereal Diseases
Commission on Tuberculosis

To the Reference Committee on New Business—

Henry Walter, Jr., Lancaster, *chairman*

Reports of:

Committee on Military Affairs
Committee to Study the Recommendations of Past President Gilson Colby Engel
Commission on Acute Appendicitis Mortality (together with the expected supplemental report)
Commission on Preventive Medicine and Public Health (together with the expected supplemental report)

To the Reference Committee on Hospital Relations—

William A. Bradshaw, Pittsburgh, *chairman*

Reports of:

Committee on Hospital Relations
Committee on Emergency Disaster Medical Service
Commission on Mental Hygiene

To the Reference Committee on Revision of Constitution and By-laws—

Walter S. Cornell, Philadelphia, *chairman*

All proposals for additions, revisions, and modifications concerning the Constitution and By-laws.

ANSWER CURRENT QUESTIONNAIRES PROMPTLY

Officers and committee members of your state medical society regret the necessity for sending questionnaires to every doctor of medicine in Pennsylvania, society and non-society members alike. Each may receive more than one questionnaire before the end of 1950. They are essential to the physical welfare of civilians and soldiers, all of whom may be suddenly exposed to injury or death during war-related emergencies.

Each physician may be needed; therefore, his whereabouts, his experience and availability must be known to those who plan in advance to meet disaster, wherever or in whatever form it may occur.

Please complete and return questionnaires promptly.

ART OF MEDICINE DEFINED

Since the turn of the century, I think it is fair to say, the advance in medical science has been greater than has been the gain in skill with which we apply this science to the welfare of the individual patient. And it is this skill which is the art of medicine, for the practice of medicine is not a science; it is the art by which we bring science to the welfare, to the aid of suffering, ill humanity, and by which we endeavor to keep people well through preventive medicine and public health.—*Medical Annals of the District of Columbia.*



HAROLD B. GARDNER, M.D.

HAROLD B. GARDNER

President-elect

HAROLD B. GARDNER, the one hundred and first president of The Medical Society of the State of Pennsylvania, was born in 1889 in New Hampton, Iowa, the county seat of Chicasaw County. His family migrated from New England to Pennsylvania and Ohio and on into Iowa in the early fifties, becoming farmers and merchants and founding the town in which he was born. His early years were spent on the farms and helping in his father's drug store, one of the first established in northeastern Iowa.

He graduated from Grinnell College at Grinnell, Iowa, in 1910 with the Bachelor of Science degree and entered Johns Hopkins Medical School in 1910, graduating in 1914 and going immediately to Pittsburgh to St. Francis Hospital as intern and later as resident in medicine. In 1916 he became general resident at Mercy Hospital, Cresco, Iowa, and assistant to the chief surgeon, Dr. George A. Kessel, an early associate of Drs. Charles and William Mayo.

In 1919 he returned to Pittsburgh to practice medicine, becoming assistant on the service of the late Dr. Benson A. Cohoe at St. Francis Hospital and associated with Dr. Cohoe in the Department of Therapeutics in the School of Medicine of the University of Pittsburgh. After Dr. Cohoe's death he became senior in medicine at St. Francis and professor of therapeutics in the School of Medicine. At the time the Elizabeth Steel Magee Hospital came under the direction of the School of Medicine, he was appointed a senior in medicine and later was similarly appointed by the Presbyterian Hospital unit of the University Medical Center.

In 1936, when his oldest son decided to study medicine, Dr. Gardner became actively interested in organized medicine, being cognizant early of the threat of socialized medicine. He has served on the board of directors of Allegheny County Medical Society and as its president in 1945. He also served in the House of Delegates of The Medical Society of the State of Pennsylvania and in the House of Delegates of the American Medical Association.

Dr. Gardner was married to Elsie Shafer of Hampton, Iowa, in 1916. They have three children—Dr. Weston D. Gardner of Wauwatosa, Wis., a member of the faculty of Marquette School of Medicine of Milwaukee, Wis.; Robert L. Gardner, with the Pennsylvania Railroad at Wheeling, W. Va.; and Jane Elizabeth Young of North Beach, Md.

Dr. Gardner is a member of the Third Presbyterian Church of Pittsburgh, of the University Club of Pittsburgh, of Nu Sigma Nu Fraternity, and of Alpha Mu Pi Omega Graduate Medical Fraternity.

Attention!

YOUR HOTEL RESERVATIONS
Should Be Made NOW!

FOR THE
One Hundredth Annual Session
PHILADELPHIA, OCTOBER 15, 16, 17, 18, 19

Name and Location	Single	Double	Twin
BELLEVUE-STRATFORD, Broad and Walnut Streets (Headquarters Hotel)	\$4.00 up	\$7.00 up	\$9.00 up
PENN SHERATON, Chestnut at 39th Street	4.00 up	6.50 up	7.00 up
BENJAMIN FRANKLIN, Chestnut at 9th Street	5.00 up	7.50 up	9.00 up
WARWICK, 17th and Locust Streets	5.00 up	.....	8.00 up
JOHN BARTRAM, Broad and Locust Streets	4.50 up	7.00 up	8.00 up
RITZ-CARLTON, Broad and Walnut Streets	5.50 up	8.00 up	8.00 up
SYLVANIA, Locust off Broad Street	4.50 up	7.50 up	7.50 up
ADELPHIA, 13th at Chestnut Street	4.50 up	7.00 up	8.00 up
ST. JAMES, 13th and Walnut Streets	3.50 up	5.50 up	5.50 up
BARCLAY, Rittenhouse Square, East	5.00 up	8.00 up	8.00 up

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager Hotel, Philadelphia, Pa.

You are requested to reserve the following accommodations during the period of the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania, October 15, 16, 17, 18, and 19, 1950, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price .
☐ Twin Bed Room with bath ☐ Suite

Arriving at a.m. p.m.
Departing at a.m. p.m.

PLEASE VERIFY MY RESERVATION

Name
Address
City and State

THE GUEST SPEAKERS

Convention Hall, Philadelphia

October 16 to 19, 1950

Monday



CHARLES S. DAVIDSON, Boston, Mass.—*The Internist's View of the Treatment of Liver Disease*—Symposium on Hepatic Cirrhosis, Monday, 10:30 a.m. Dr. Davidson, a graduate of McGill University, was certified by the American Board of Internal Medicine in 1946. He is assistant professor of medicine at Harvard Medical School and a staff member of the Boston City Hospital. Dr. Davidson is a member of the Council on Foods and Nutrition of the American Medical Association and has done considerable research in the field of hepatic disease with particular emphasis on nutrition and protein metabolism.



ROBERT R. LINTON, Boston, Mass.—*The Surgical Management of Hepatic Cirrhosis*—Symposium on Hepatic Cirrhosis, Monday, 11:00 a.m., and *The Surgical Treatment of the Postphlebotic Syndrome*—Symposium on Peripheral Vascular Diseases, Monday, 4:20 p.m. Dr. Linton, a graduate of Harvard Medical School, was certified by the American Board of Surgery in 1939. He is assistant professor of clinical surgery at Harvard, a member of the staff of the Newton-Wellesley Hospital, Newton, Mass., and consulting surgeon of the Massachusetts Eye and Ear Infirmary, Boston.



WILLIAM A. ALTEMEIER, Cincinnati, Ohio—*The Present Status of Antibiotic and Chemotherapeutic Agents in Surgery*—Symposium on Antibiotics and Chemotherapeutic Agents, Monday, 2:10 p.m. Dr. Altemeier, a graduate of the University of Cincinnati, was certified by the American Board of Surgery in 1940. He is assistant professor of surgery at the University of Cincinnati and a staff member of Cincinnati General Hospital, Children's Hospital, Holmes Hospital, and Christ Hospital.



IRVING S. WRIGHT, New York City—*The Use and Abuse of Anticoagulant Drugs*—Symposium on Peripheral Vascular Diseases, Monday, 3:35 p.m. Dr. Wright, a graduate of Cornell University Medical School, was certified by the American Board of Internal Medicine in 1937 and certified in his specialty of cardiovascular diseases in 1940. He is professor of clinical medicine at Cornell University

and chief of the vascular section of the department of medicine of Cornell University Medical School and New York Hospital. Dr. Wright is consultant in medicine to the Surgeon General of the United States Army and chairman of the publication committee of *Circulation*, the journal of the American Heart Association.

Tuesday



RICHARD H. OVERHOLT, Boston, Mass.—*Benefits of Surgery in Pulmonary Tuberculosis*—Symposium on Pulmonary Tuberculosis, Tuesday, 9:40 a.m. Dr. Overholt, a graduate of the University of Nebraska, was certified by the American Board of Surgery in 1937. He is clinical professor of surgery at Tufts College and is a member of the staff at Joseph H. Pratt Diagnostic Hospital, New England Baptist Hospital, and New England Deaconess Hospital, as well as consultant in thoracic surgery in several state and county tuberculosis hospitals.



RUSSELL L. CECIL, New York City—*Treatment of Rheumatoid Arthritis*—Section on Medicine, Tuesday, 11:30 a.m. Dr. Cecil, a graduate of the Medical College of Virginia, was certified by the American Board of Internal Medicine in 1936. He is professor of clinical medicine at Cornell University Medical School and senior consultant at the Bronx V.A. Hospital. Dr. Cecil is editor of *Cecil's Textbook of Medicine*.



SUMNER L. KOCH, Chicago, Ill.—*Immediate Treatment of Hand Injuries*—Section on Surgery, Tuesday, 11:25 a.m. Dr. Koch, a graduate of Northwestern University, was certified by the American Boards of Surgery and Plastic Surgery in 1939. He is professor of surgery at Northwestern University and attending surgeon at Passavant Memorial Hospital.



GEORGE A. WOLF, JR., New York City—*Headache*—Section on Medicine, Tuesday, 2:15 p.m. Dr. Wolf, a graduate of Cornell University Medical School, was certified by the American Board of Internal Medicine in 1948. He is assistant professor of clinical medicine at Cornell and attending physician and chairman of the Committee on

Social and Vocational Restoration of New York Hospital.



FRANCIS D. MOORE, Boston, Mass.—*The Effect of Definitive Surgery on the Natural Course of Duodenal Ulcer Discase*—Symposium on Acute Conditions within the Abdomen, Section on Surgery, Tuesday, 2:20 p.m. Dr. Moore, a graduate of Harvard University, was certified by the American

Board of Surgery in 1946. He is Mosely professor of surgery at Harvard, consulting surgeon at Massachusetts General Hospital, and a member of the associate staff at Peter Bent Brigham Hospital.



STUART W. HARRINGTON, Rochester, Minn.—*The Diagnosis and Treatment of Intrathoracic Tumors*—Section on Surgery, Tuesday, 4:20 p.m. Dr. Harrington, a graduate of the University of Pennsylvania School of Medicine, was certified by the American Board of Surgery in 1937. He

is professor of surgery at the Mayo Foundation Graduate School of Medicine, University of Minnesota, and head of the section of general surgery and thoracic surgery at the Mayo Clinic.

Wednesday



WILL C. SPAIN, New York City—*The Case for Histamine as the Basis of Allergic Reactions: Attempts at Its Neutralization*—Section on Medicine, Wednesday, 11:25 a.m. Dr. Spain, a graduate of Vanderbilt University, was certified by the American Board of Internal Medicine (allergy)

in 1937. He is clinical professor of medicine at the New York Post-Graduate School of Medicine. He is also in charge of the Department of Allergy at the University Hospital and the Fourth Medical Division, New York University, and is a past president of the American Academy of Allergy.



FRANK H. LAHEY, Boston, Mass.—*Malignancy of the Stomach and Total Gastrectomy*—Section on Surgery, Wednesday, 11:30 a.m. Dr. Lahey, a graduate of Harvard Medical School, was certified by the American Board of Surgery in 1937. He is director of the Lahey Clinic, surgeon-in-chief to

the New England Baptist Hospital, and surgeon of the New England Deaconess Hospital. Dr. Lahey is a past president of the American Medical Association, New England Surgical Association, and Interstate Postgraduate Medical Association.

EDWARD G. WATERS, Jersey City, N. J.—*Modern Concepts of Endocrinologic Therapy in Pregnancy*—Section on Surgery, Wednesday, 2:20 p.m. Dr. Waters, a graduate of Harvard University Medical School, was certified by the American Board of Obstetrics and Gynecology in 1935. He is assistant professor of obstetrics and gynecology at Columbia University, associate sur-

geon at the Jersey City Medical Center, and attending surgeon at Christ Hospital and Fairmont Hospital. Dr. Waters is also division chief of obstetrics at the Margaret Hague Maternity Hospital and consultant in obstetrics and gynecology at the Monmouth Memorial Hospital and Patterson General Hospital.



FRANCIS F. SCHWENTKER, Baltimore, Md.—*Diagnosis and Management of Rheumatic Fever*—Section on Medicine, Wednesday, 2:20 p.m. Dr. Schwentker, a graduate of Johns Hopkins University School of Medicine, has been professor of pediatrics at Johns Hopkins University School of Medicine and pediatrician-in-chief at the Johns Hopkins Hospital since 1946. He is editor of *Pediatrics*, *Medicine*, and *The Intern*.

Thursday



BURRILL B. CROHN, New York City—*Medical Aspects of Regional Ileitis*—Symposium on Ulcerative Lesions of the Bowel, Thursday, 9:15 a.m. Dr. Crohn, a graduate of Columbia University College of Physicians and Surgeons, was certified by the American Board of Internal Medicine in 1937. He is consultant gastro-enterologist to the Mt. Sinai Hospital and is author of a book entitled *Regional Ileitis*. Dr. Crohn is consulting physician to the Beth Israel Hospital, Newark, N. J., St. Joseph Hospital, Far Rockaway, and Rockaway Beach Hospital.



RICHARD B. CATTELL, Boston, Mass.—*Surgical Aspects of Ulcerative Colitis and Regional Enteritis*—Symposium on Ulcerative Lesions of the Bowel, Thursday, 9:45 a.m., and *The Surgical Treatment of Benign Lesions of the Pancreas*—Section on Surgery, Thursday, 11:25 a.m. Dr. Cat-

tell, a graduate of Harvard University Medical School, was certified by the American Board of Surgery in 1937. He is surgeon at the Lahey Clinic and New England Baptist Hospital and chief surgeon at the New England Deaconess Hospital.



CLAYTON B. ETHRIDGE, Washington, D. C.—*Diagnosis and Therapy in Various Forms of Coronary Heart Disease*—Section on Medicine, Thursday, 11:30 a.m. Dr. Ethridge, a graduate of the University of Virginia, was certified by the American Board of Internal Medicine in 1940.

He is clinical professor of medicine at George Washington University School of Medicine and consultant in internal medicine at the U. S. Naval Hospital, Bethesda, and the Mt. Alto Veterans Hospital, Washington. Dr. Ethridge is chief of the cardiovascular section of the George Washington Hospital and the Gallinger Municipal Hospital. He was cardiologist and medical consultant aboard the U. S. Hospital Ship *Benevolence* at Operations "Crossroads."

SPECIAL CONVENTION FEATURES

RELIGIOUS HOUR

IRVINE AUDITORIUM, UNIVERSITY OF PENNSYLVANIA
34th and Spruce Streets

Sunday, October 15, 1950

3:45 p.m.

Organ Recital JOSEPH D. CHAPLINE, JR., A.G.O.
Air for G String J. S. BACH
Fugue on Kyrie COUPERIN
March HANDEL
Fanfare LEMMENS
Adagio in C J. S. BACH

4:00 p.m.

Processional—A Mighty Fortress Is Our God, LUTHER
Opening Prayer—
REV. W. HAMILTON AULENBACK, Christ Church and
St. Michael's (Episcopal), Philadelphia.

Anthem—Praise Ye the Name TCHEREPNIN

Address—

BERTRAM W. KORN, D.D., Keneseth Israel Congrega-
tion, Philadelphia.

Hymn—We Gather Together arr. KREMSER

Address—

REV. W. HAMILTON AULENBACK.

Anthem—Panis Angelicus CASCIOLINI

Address—

JOHN S. LADD THOMAS, D.D., Temple University
School of Theology, Philadelphia.

Closing Prayer REV. W. HAMILTON AULENBACK

Recessional—God Bless Our Native Land

.....Harmonica Anglicana arr. MAHLMANN

Postlude—Toccata WIDOR

Music by Men's Glee Club, University of Pennsylvania,
under the direction of Robert S. Godsall.



The Angelairens, students of the great Carlos Salzedo, will present "Holiday for Harpstrings" at the Third Annual State Dinner. Also on the program will be Edward Roecker, famous baritone singing star of radio and television. Tickets for the dinner are \$5.00 each and should be ordered in advance on the form opposite page 1008.

SUNDAY BUFFET SUPPER

Following the Religious Hour, a buffet supper will be held at 5:30 p.m. in Houston Hall which is adjacent to Irvine Auditorium. Tickets for this supper are \$2.00 each, and reservations should be made now on the form appearing on page 1008.

INSTALLATION MEETING

BALLROOM, BELLEVUE-STRATFORD HOTEL

Tuesday, October 17, 1950

8:00 p.m.

Organ Recital KATHERINE GILLES, Organist

8:15 p.m.

Call to Order by the President.

E. ROGER SAMUEL, Mt. Carmel.

Invocation.

In Memoriam.

M. FRASER PERCIVAL, Philadelphia, Chairman of the Committee on Necrology.

Address of Welcome.

HENRY B. KOBLER, Philadelphia, President, Philadelphia County Medical Society.

Music.

Installation of the President.

Address of the President.

HAROLD B. GARDNER, Pittsburgh.

Bestowal of Awards:

Benjamin Rush Group Award and Benjamin Rush Individual Award.

Music.

Address to Graduates.

WALLACE M. YATER, Washington, D. C.

Presentation of certificates to members who have completed the three-year course of the Graduate Education Institute of The Medical Society of the State of Pennsylvania.

ALUMNI DINNERS AT PHILADELPHIA SESSION

The alumni of five medical schools are planning to hold dinners on Wednesday evening, October 18, during the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania. In each instance the program will be completed in time to permit attendance at the annual President's Reception and Dance which will be held in the ballroom of the Bellevue-Stratford Hotel at 9:00 p.m.

Space has been allocated in the Technical Exhibit at Convention Hall for registering alumni by each of the schools. Tickets for the dinners will be on sale there until Wednesday noon.

The *University of Pennsylvania* alumni will hold their dinner at the Hotel Warwick at 6:00 p.m. Advance registrations may be made through the Alumni Office, 36th and Pine Streets, Philadelphia 4.

The *University of Pittsburgh* alumni will hold their dinner at 6:00 p.m. in the North Garden of the Bellevue-Stratford Hotel. Advance registrations can be made through the executive office of the Allegheny County Medical Society, Jenkins Building, Pittsburgh 22.

The *Jefferson Medical College* alumni will hold their dinner at 6:30 p.m. in the Burgundy Room of the Bellevue-Stratford Hotel. Advance registrations can be made through the Alumni Office, Tenth and Sansom Streets, Philadelphia 7.

The *Temple University* alumni will hold their dinner at 6:30 p.m. at Palumbo's Cafe and Restaurant, Eighth and Catherine Streets. Advance registrations can be made through Charles Q. DeLuca, M.D., 255 South 17th Street, Philadelphia 3.

The *Hahnemann Medical College and Hospital* alumni will hold their dinner at 6:30 p.m. in the Union League, Broad and Sansom Streets. Advance registrations may be made through Carl C. Fischer, M.D., 230 North Broad Street, Philadelphia 2.

COLOR TELEVISION

Television in color will be presented at the Annual Session on Monday, Tuesday, and Wednesday from the Hospital of the University of Pennsylvania.

The morning program of each day will be a surgical presentation by the staff of the Hospital of the University of Pennsylvania. Participating in these morning programs, which will run from 10 a.m. to 12 noon on Monday and from 8:30 a.m. to 10:30 a.m. on Tuesday and Wednesday, will be: Drs. Isidor S. Ravdin, Franklin L. Payne, Paul C. Colonna, Jonathan P. Rhoads, Julian Johnson, Paul O. Klingensmith, Harold A. Zintel, George L. Hoffman, Jr., and William T. Fitts, Jr.

The afternoon programs will be medical pro-

grams presented from 1 p.m. to 3 p.m. by the medical staffs of Jefferson Medical College, the Graduate School of Medicine of the University of Pennsylvania, and the Temple University School of Medicine.

Monday afternoon has been assigned to the staff of Jefferson Medical College and the participants will be: Drs. Hobart A. Reimann, Henry V. Decker, Anthony F. DePalma, Frederick B. Wagner, Jr., John D. Reese, Franklin R. Miller, and Paul C. Swenson.

The Graduate School of Medicine of the University of Pennsylvania will conduct the program on Tuesday afternoon and the following physicians will appear on the television screen: Drs. Ella Roberts, Melville A. Goldsmith, Frederick A. Bothe, Frederick Monaghan, Samuel B. Had-

den, John H. Gibbon, Jr., and Richard H. Chamberlain.

The television program will be concluded on Wednesday afternoon by the staff of the Temple University School of Medicine. Included on this program are: Drs. Sherman F. Gilpin, Jr., John V. Blady, William Harry Perloff, W. Emory Burnett, W. Edward Chamberlain, Chevalier L. Jackson, and Charles M. Norris.

The entire three-day program, which is being presented through the courtesy of the Smith, Kline & French Laboratories, will be in charge of the Television Subcommittee of the Committee on Scientific Work which is composed of the following Philadelphians: Drs. George P. Rosemond, James R. Kitchell, R. Bruce Nye, and Kendall A. Elsom, chairman.

THE TECHNICAL EXHIBIT

Eighty-seven commercial firms have prepared elaborate exhibits of the newest equipment, pharmaceuticals, appliances, books, and foods, which represent their contribution towards the improvement of the practice of medicine.

These manufacturers and distributors have been largely responsible, through the purchase of space, for the financing of this session. Every physician should take time to show his appreciation by visiting and registering at each booth.

The Technical Exhibit, which will be on the ground floor of Convention Hall, will be open Monday from 10:00 a.m. to 5:30 p.m., Tuesday and Wednesday from 8:30 a.m. to 5:30 p.m., and Thursday from 8:30 a.m. to 2:00 p.m.

The Abbott Laboratories, North Chicago, Ill. (Space 302).

Air-Shields, Inc., Hatboro, Pa. (Space 208): They will exhibit their Isolette Infant Incubator and their Croupette Humidity and Oxygen Tent. The Isolette is an isolation-type incubator and remains constantly closed at all times. Access to the child is gained wholly through entry ports in the unit's plexiglas hood. The infant is therefore given the benefit of unchanging atmospheric conditions. The Croupette is a unique device whereby it is possible to provide high relative humidity without heat, in combination with the administration of oxygen for the treatment of acute respiratory difficulties.

A. S. Aloe Co., St. Louis, Mo. (Space 236).

American Hospital Supply Corp., Evanston, Ill. (Space 313).

Ames Company, Elkhart, Ind. (Space 315).

Ayerst, McKenna & Harrison, Ltd., New York City (Space 325).

The Baker Laboratories, Cleveland, Ohio (Space 134).

J. Beeber Co., Inc., Philadelphia, Pa. (Space 206).

Beech-Nut Packing Company, New York City (Space 420).

Bilhuber-Knoll Corp., Orange, N. J. (Space 335): Visit this booth for the latest information about the original medicinal chemicals, Dilaudid, Metrazol, Theocalcin, Octin, and Bromural. Valoctin, a combination of Octin and Bromural, and Quadrinal, a well-tolerated anti-asthmatic preparation, are the newer products which will be of interest. Your discussions of these and other time-proven medicinal chemicals will be welcomed.

The Borden Company New York City (Space 308): Borden's Infose brand syrup for infants is a concentrate of selected apple juice standardized for pectin and partially neutralized for milk modification. A completely natural product containing the naturally occurring sugars, Infose supplies pectin and available organic iron in one convenient source for the infant's formula. Ask for complete data at this booth.

Brewer & Company, Inc., Worcester, Mass. (Space 212): This exhibit will consist of specialties centering around Thesodate, the original enteric-coated tablet of theobromine sodium acetate; Amchlor, the enteric-coated one-gram tablet of ammonium chloride; Gel-ets, the newest mode in oral vitamin therapy; A-Vita and Hi-A-Vita (high potency vitamin A preparations); and Panplex C (vitamin B complex with C). Also exhibited will be other specialties including Soduxin (sodium succinate—Brewer) and Injectable Quinidine Hydrochloride for use when it cannot be given orally.

Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y. (Space 320): A completely new type antihistaminic, Perazil brand chlorcyclizine hydrochloride will be featured in this exhibit. Perazil differs chemically in that it is a piperazine rather than a conventional ethylenediamine compound, and a single dose provides 12 to 24 hour action. We will also feature 'Wellcome' brand globin insulin, the accepted intermediate-acting insulin, and Digoxin, for safe predictable digitalization.

Cambridge Instrument Co., Inc., New York City (Space 244).

Camel Cigarettes, New York City (Spaces 343 and 345).

Ciba Pharmaceutical Products, Inc., Summit, N. J. (Space 521): You are invited to visit this exhibit which will feature Priscoline Hydrochloride, an adrenergic and sympatholytic agent that produces peripheral vasodilatation. Representatives in attendance will gladly discuss the role of Priscoline in the treatment of peripheral vascular disease.

The Coca-Cola Co., Atlanta, Ga. (Space 203).

F. A. Davis Co., Philadelphia, Pa. (Space 204).

The Doho Chemical Corp., New York City (Space 314).

Duke Laboratories, Inc., Stamford, Conn. (Space 210).

S. F. Durst & Co., Inc., Philadelphia, Pa. (Space 526).

Eaton Laboratories, Inc., Norwich, N. Y. (Space 327).

J. H. Emerson Company, St. Davids, Pa. (Space 321).

Endo Products, Inc., Richmond Hill, N. Y. (Space 237).

H. G. Fischer & Company, Franklin Park, Ill. (Space 123).

General Electric X-Ray Corp., Philadelphia, Pa. (Space 340).

Gerber Products Co., Fremont, Mich. (Space 228): Whether it is a baby feeding problem or a problem of an adult's alimentary tract, we can serve you with a complete line of good-to-eat strained and junior foods. New editions of baby care books are available. The 1950 Special Diet Recipes, edited by a nutritionist, gives many smooth, simplified, and palatable diets.

H. J. Heinz Company, Pittsburgh, Pa. (Space 220).

Junket Brand Foods, Little Falls, N. Y. (Space 232).

Keeler Optical Products, Ltd., Philadelphia, Pa. (Space 235): A comprehensive display of new English ophthalmic instruments including the new measuring ophthalmoscope with wide angle view of measuring retinal distances. A slit lamp illuminator for new polarized ophthalmoscope with no corneal reflex and a dynamic retinoscope will be shown. A full range of EENT diagnostic sets will be displayed. Be sure to inspect the direct and indirect ophthalmoscope that provides really brilliant illumination.

Kelley-Koett Manufacturing Co., Inc., Covington, Ky. (Space 311): A cordial invitation is extended to all members of the Society to visit this booth. On display will be several modern units of medical x-ray equipment along with x-ray accessories and supplies. Courteous representatives will be in attendance to answer your inquiries.

Lea and Febiger, Philadelphia, Pa. (Space 218).

Lederle Laboratories Division, New York City (Space 125).

Charles Lentz & Sons, Philadelphia, Pa. (Spaces 331 and 333).

The Liebel-Flarsheim Co., Cincinnati, Ohio (Spaces 143 and 145).

Eli Lilly and Company, Indianapolis, Ind. (Space 326).

J. B. Lippincott Company, Philadelphia, Pa. (Space 427).

McKenna Drug Company, Inc., Pittsburgh, Pa. (Space 120).

McNeil Laboratories, Inc., Philadelphia, Pa. (Space 524).

M & R Dietetic Laboratories, Columbus, Ohio (Space 207): Representatives for Similac and Cerevim will appreciate the opportunity to discuss with you the merits and use of these products in the field of infant and child nutrition.

Maico of Pennsylvania, Philadelphia, Pa. (Space 341).

Maltbie Laboratories, Newark, N. J. (Space 132).

Mead Johnson & Co., Evansville, Ind. (Space 139).

Medical Case History Bureau, New York City (Space 242): Medical Case History Bureau suggests: be a modern minute man who records his patients' minutes in fewer minutes with the hours-saving Info-dex System. Your present history charts can be easily incorporated, without rewriting, into a streamlined new system which has special features like cross-index for quick reference, cotter pin for ever-hold, never-lose charts. Many physicians consider concise Info-dex charts a 'must.' See the Info-dex demonstration at booth 242.

The Medical Protective Co., Fort Wayne, Ind. (Space 323): The members of The Medical Society of the State of Pennsylvania are invited to visit this exhibit

and discuss with the representative how this company meets the exacting requirements of adequate liability protection which are peculiar to the professional liability field.

Medical Service Association of Pennsylvania, Harrisburg, Pa. (Space 332): The latest information of interest to the medical profession concerning Blue Shield, the non-profit, voluntary, prepaid medical care plan in Pennsylvania, will be available at this exhibit. The display will be entirely new, prepared especially for the one hundredth annual session. With Blue Shield membership now more than 750,000 in the State, doctors need to know all about the plan. New practicing physicians are invited to stop at this exhibit for application forms to become participating doctors. Staff representatives will be present to answer all questions.

Merck & Co., Inc., Rahway, N. J. (Space 234).

The Wm. S. Merrell Company, Cincinnati, Ohio (Space 318).

The C. V. Mosby Company, St. Louis, Mo. (Space 133.)

National Dairy Council, Chicago, Ill. (Space 316).

The National Drug Company, Philadelphia, Pa. (Space 131).

Nepera Chemical Co., Inc., Yonkers, N. Y. (Space 238): This display will feature illuminated color illustrations showing the pathology of infections of the bladder and kidney. Mandelamine^R (brand of methenamine mandelate) will be the product on display. Indicated in urinary infections, Mandelamine is effective in a wide antibacterial range without risk of drug-fastness.

Nestle's Milk Products, Inc., New York City (Space 330).

Paravox, Inc., Cleveland, Ohio (Space 205).

Parke, Davis & Company, Detroit, Mich. (Space 239): Medical service members of the Parke, Davis & Company staff will be in daily attendance at this exhibit for consultation and discussion of the various products listed in their pharmaceutical, antibiotic, and biologic catalog. Important specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxytel, Thrombin Topical, Influenza Virus Vaccine, and others will be featured. You are most cordially invited to visit this exhibit with the assurance that your personal interest will indeed be very much appreciated.

The E. L. Patch Company, Stoneham, Mass. (Space 140).

Pennsylvania Pharmaceutical Association, Harrisburg, Pa. (Space 334): The Pennsylvania Pharmaceutical Association, in cooperation with the Division of Narcotic Drug Control of the Pennsylvania Department of Health, in celebrating National Pharmacy Week, will present a historical exhibit on pharmacy and narcotics.

Pet Milk Company, St. Louis, Mo. (Spaces 336 and 338): A miniature working model of an evaporated

milk plant will be exhibited. This exhibit offers an opportunity to obtain information about the production of Pet Milk, its use in infant feeding, and the time-saving services available to physicians. Miniature Pet Milk cans will be given to the physicians who visit the booth.

Philip Morris & Company, Ltd., Inc., New York City (Space 300): This exhibit will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Picker X-Ray Corp., New York City (Space 304).

George P. Pilling & Son Company, Philadelphia, Pa. (Spaces 337 and 339): On display will be a line of both general and specialized instruments for eye, ear, nose and throat, bronchoscopy, thoracic and neurosurgery, as well as several items in the hospital equipment line, such as the new Pilling suction and pressure apparatus. Visit the Pilling display for the latest designs in surgical instruments and equipment.

The Procter & Gamble Company, Cincinnati, Ohio (Space 317).

L & B Reiner, Inc., New York City (Space 241).

Rittenhouse Book Store, Philadelphia, Pa. (Space 421): Philadelphia's medical book store always has on hand for your examination the current books of all publishers of medical and associated sciences. Its shelves carry the books of almost 200 publishers, and its exhibit will give a sample of these books. Its service includes out-of-print books, journals, journal sets, and a binding service for your reprints and journals.

A. H. Rohins Company, Inc., Richmond, Va. (Space 129).

Rystan Company, Inc., Mount Vernon, N. Y. (Space 138): This exhibit will present Chloresium Ointment and Chloresium Solution (Plain), which contain the purified, therapeutically active water-soluble derivatives of chlorophyll. They are natural, nontoxic agents for the topical treatment of wounds, burns, ulcers, and dermatoses. These tissue-stimulating preparations promote the growth of healthy granulation tissue and deodorize malodorous conditions by inhibiting the action of anaerobic proteolytic bacteria.

Sanborn Company, Cambridge, Mass. (Space 222): Sanborn instruments to be shown will include the direct-writing Viso-Cardiette; the photographic Instomatic Cardiette; the Metabulator, latest model metabolism tester; and the new Electrophrenic Respirator. Full data will also be available concerning the Sanborn Poly-Viso (multi-channel biophysical research recorder), the Electro-manometer (for pressure recordings), and other new instruments for cardiac and other research, teaching, and diagnosis.

Sandoz Pharmaceuticals, New York City (Space 230).

Saratoga Springs Authority, Saratoga Springs, N. Y. (Space 137).

W. B. Saunders Company, Philadelphia, Pa. (Spaces 128 and 130): All doctors attending the meeting of The Medical Society of the State of Pennsylvania are invited to visit this exhibit where there will be displayed a complete line of books, including Hyman's *Integrated Practice of Medicine*, Bockus' *Postgraduate Gastroenterology* and *Cytologic Diagnosis of Cancer*, Wells' *Clinical Pathology*, Wolff's *Electrocardiology*, Mitchell and Nelson's *Pediatrics*, Hauser's *Diseases of the Foot*, Nesselrod's *Proctology*, and Williams' *Textbook of Endocrinology*. Also displayed will be Custer's *Atlas of Blood and Bone Marrow*, Sunderman and Boerner's *Normal Clinical Values*, Friedberg's *Diseases of the Heart*, Dry's *Cardiology*, Jamney's *Medical Gynecology*, Levine and Harvey's *Clinical Auscultation of the Heart*, Boies' *Otolaryngology*, and many other new books and new editions.

Schering Corporation, Bloomfield, N. J. (Space 240): Buccal tablets of Oreton, Progynon, Proluton, and Cortate with the exclusively new base, Polyhydrol, will be featured at the Schering exhibit. Polyhydrol makes possible complete absorption of hormones via the buccal route providing advantages of high effectiveness, convenience, and economy. Trimeton and Chlor-Trimeton, two outstanding antihistamines, and Coricidin, Schering's new treatment for the common cold, containing Chlor-Trimeton, aspirin, phenacetin, and caffeine, will high-light the exhibit. Representatives will be present to welcome you and will be happy to answer inquiries concerning their new products as well as their other hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

G. D. Searle & Co., Chicago, Ill. (Space 328).

Sharp & Dohme, Inc., Philadelphia, Pa. (Space 306): Meriting special attention at this exhibit will be the stable, portable 'Lyovac' Normal Human Plasma irradiated to destroy viral contaminants that might cause homologous serum hepatitis. Unusual specialties including 'Cremo' sulfonamides, pleasantly flavored, palatable suspensions of the most effective systemic and enteric sulfonamides, and 'Delmor,' a delicious nutrient powder, also will be of major interest.

Smith, Kline & French Laboratories, Philadelphia, Pa. (Space 319): The displayed 'Dexamyl'—S.K.F.'s balanced combination of 'Dexedrine' Sulfate (dextro-

amphetamine sulfate, S.K.F.) and 'Amytal' (Amobarbital, Lilly)—is a new preparation of wide usefulness in everyday practice. Combined in 'Dexamyl,' Dexedrine and Amytal work together to provide symptomatic relief from mental and emotional distress.

Spencer, Incorporated, New Haven, Conn. (Space 126).

E. R. Squibb & Sons, Long Island City, N. Y. (Spaces 122 and 124).

Stethetron Sales Company, Wenonah, N. J. (Space 135): This exhibit will demonstrate Council-accepted electronic stethoscopes which employ electronics to amplify the faintest cardiac murmur, fetal heart sound, or respiratory rale. The pocket-size unit compensates for office noise level and likely hearing deficiencies at high and low frequencies. Connect the stethoscope to many cardiographs for sound tracings—connect the stethoscope to wire recorders. Hear and determine the progress of a lesion by play back. You are invited to determine whether they can improve your auscultation.

U. S. Vitamin Corporation, New York City (Space 426).

Universal Products Corp., Norristown, Pa. (Space 522): You've often wished to have a light at the end of your finger. The new "Surgeon's Fingalyte" to be shown in this exhibit is just that. Bulb on finger tip, it penetrates into all cavities, gives perfect cold transillumination, and saves the physician's time. Other features include a headlight (weighing only two ounces) and all of your diagnostic lighting needs contained in a small case. Also shown will be the surgeon's "X-L-Lyte," with a record of over 8000 in use.

The Upjohn Company, Kalamazoo, Mich. (Space 329).

Varick Pharmacal Co., Inc., New York City (Space 305).

Westinghouse Electric Corp., Philadelphia, Pa. (Spaces 214 and 216).

White Laboratories, Inc., Newark, N. J. (Space 136).

Winthrop, Stearns, Inc., New York City (Space 312).

Wyeth, Incorporated, Philadelphia, Pa. (Space 118).

ANSWER CURRENT QUESTIONNAIRES PROMPTLY

Officers and committee members of your state medical society regret the necessity for sending questionnaires to every doctor of medicine in Pennsylvania, society and non-society members alike. Each may receive more than one questionnaire before the end of 1950. They are essential to the physical welfare of civilians and soldiers, all of whom may be suddenly exposed to injury or death during war-related emergencies.

Each physician may be needed; therefore, his whereabouts, his experience and availability must be known to those who plan in advance to meet disaster, wherever or in whatever form it may occur.

Please complete and return questionnaires promptly.

THE SCIENTIFIC EXHIBIT

HURLEY L. MOTLEY, M.D., Philadelphia, *Chairman*

The Scientific Exhibit of the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania will be located on the ground floor of Convention Hall, Philadelphia. The exhibit will be open Monday from 10:00 a.m. to 5:30 p.m., Tuesday and Wednesday from 9:00 a.m. to 5:30 p.m., and Thursday from 9:00 a.m. to 2:00 p.m.

The exhibit which consists of 42 displays is worthy of the attention of every registrant. The exhibitors have spent much time, research, and effort in order to present to the Society and its guests those phases of medicine which are new, important, and of interest to the practicing physician. The Committee on Scientific Exhibits requests that you visit the exhibits often during the convention.

Artistically hand-engrossed Awards of Merit will be presented to the two exhibitors whose exhibits are adjudged by a review committee as ranking first and second in point of educational value and interest to the general practitioner of medicine. Exhibits sponsored by committees or non-members of the State Society, by outside groups, whether organized medical clinics, non-medical groups, etc., or by previous prize-winning exhibits, are not eligible for competition.

Provision has been made in the scientific programs for a recess to view exhibits.

S-406. Neurosurgery Motion Pictures — Rudolph Jaeger and William H. Whiteley, Jefferson Medical College and Hospital, Philadelphia.

A motion picture presentation in color of neurologic surgical problems will be shown. The films have been especially prepared for the instruction of the general practitioner and those specialists interested in keeping abreast with current advances in this field. The following problems will be presented: diagnosis of spinal and spinal cord disorders by roentgenographic use of pantopaque, diagnosis of brain disorders by the injection of air, treatment of spinal cord injury, frontal lobe tumor (diagnosis and operative removal), intracranial meningioma (diagnosis and treatment), epidermoid tumor of cerebellopontine angle (diagnosis and treatment), and prefrontal lobotomy for treatment of mental diseases and pain of malignancy.

Additional subjects which will be presented are: chronic traumatic sciatic neuritis (treated by lumbar

sympathectomy), spinal cord tumor (diagnosis and treatment), diagnosis and treatment of intervertebral disk injury causing backache and sciatica, craniopharyngioma, subdural hematoma, treatment of compound depressed fracture of the skull, anatomy, diagnosis, and treatment of tic douloureux, brain abscess, removal of intra-orbital tumor, and depressed fracture of skull.

S-407. Congenital Gynatresia — Glenn S. Dickson, Episcopal Hospital, Philadelphia.

The exhibit will consist of seven serial drawings in color with appropriate descriptions illustrating operative procedures in the correction of congenital gynatresia (with hematocolpos, hematometra, and bilateral hematosalpinx) in a patient aged 21 years. It is the purpose of this demonstration to show the necessity of thorough physical and pelvic examination and treatment of young females who do not menstruate at the usual time of the menarche.

S-408. Choice of Therapy in Pulmonary Tuberculosis (With Emphasis on Extrapleural Pneumothorax) — Jacob W. Cutler, Philadelphia.

The development of modern collapse therapy, excisional surgery, and the introduction of antibiotics has made the treatment of pulmonary tuberculosis increasingly complex and difficult. Integration of therapy with careful planning of the over-all therapeutic attack is therefore essential.

The exhibit will consist of statistical data, translight x-ray reproductions, drawings and charts, and place emphasis on extrapleural pneumothorax, an important but neglected and undervalued collapse measure. It is a procedure aimed to produce a selective collapse of the part of the lung involved by means of an air pocket which is made by stripping the pleural layers off the inner surface of the chest wall. This air pocket is maintained with pneumothorax refills or replaced with oil.

The operation is not intended to replace thoracoplasty or other collapse measures. It has an importance all its own and fills a distinct gap in the collapse therapy program. Its greatest usefulness is in extensive bilateral disease when intrapleural pneumothorax is impossible, in active disease when collapse is urgently needed but pneumothorax is unsatisfactory, and when phrenic nerve interruption and pneumoperitoneum are considered inadequate and a thoracoplasty or pneumonectomy carries too great a risk. It is preferable to thoracoplasty in young women because of the deforming result of the latter and in the elderly because of the greater hazard of thoracoplasty.

S-409. Experimental Recanalization of the Fallopian Tube — Mario A. Castallo, Amos S. Wainer, and John M. Stack, Jefferson Medical College and Hospital, Philadelphia.

The exhibit will be a series of photographs together with drawings of an experiment performed in the research laboratory of the Jefferson Medical College Hospital to ascertain whether or not fallopian tubes would bridge over a segment which had been removed surgically, both anatonically and histologically.

The experiments were carried out by using female monkeys from which 2 to 3 centimeters of the fallopian tube had been removed. Various materials were placed in the gap to note the degree of bridging, among which were whalebone, stainless steel wire, and polyethylene tubing. The polyethylene tubing proved to be the most efficacious as a gapping material, for the tube recanalized itself both anatonically and histologically.

The exhibit will show the several steps in the surgical technique of the operative procedure and the resulting anatomic and physiologic recanalization by photographic and microscopic pictures.

S-410. The Surgery of Stenotic Valvular Disease of the Heart—Charles P. Bailey, Robert P. Glover, and Thomas J. E. O'Neill, Hahnemann Medical College and Hospital and Episcopal Hospital, Philadelphia.

This exhibit will graphically depict from an etiologic and anatomic standpoint the types of valvular disorders of the heart which are amenable to surgical treatment at the present time. Our total experience with such surgery and the methods used for it will also be graphically portrayed by actual photographs, diagrams, and charts of completed cases.

S-411. Plastic and Reconstructive Surgery — Hans May and Richard S. Oakey, Jr., Lankenau Hospital, Philadelphia.

Examples of reconstruction and repair of hand injuries will be shown with special emphasis on the closure of surface defects of the hands by skin grafts and flaps and results after tendon grafting. Transparencies of drawings of rhinoplasty and transplantation of tendons will be shown as will the results after rhinoplasty, repair of harelips, and breast plasty.

S-412. Ten Years' Experience with Sulfonamides in the Prophylaxis of Rheumatic Fever—Ella Roberts, Children's Heart Hospital, Philadelphia.

Charts and graphs will be shown of: (1) patient years of rheumatic susceptibles treated with sulfanilamide, sulfadiazine, sulfamerazine, and sulfamerazine and sulfadiazine; (2) toxic reactions, incidence, and severity; (3) dose; (4) clinical and laboratory observations; and (5) recurrence rate (less than 1 per cent). A report of recurrences in former patients who discontinued the use of sulfonamides against advice will also be given.

S-413. Pathologic Anatomy of Diseases of the Nervous System—George Wilson, Charles Rupp, Jr., Helena E. Riggs, and Elizabeth B. Eken, Philadelphia General Hospital, Philadelphia.

Kodachrome slides showing representative examples of common vascular lesions, neoplasms of the nervous system, infections, trauma, and other neurologic conditions, will be projected on a small ground glass screen. The slides will be chosen to show the more common neurologic conditions encountered at the postmortem table and will be selected chiefly from conditions which

are likely to be of interest to the general practitioner rather than the specialist in neurology.

S-414. Commission to Study the Control of Rheumatic Fever—The Medical Society of the State of Pennsylvania.

S-415. Aortic Arch Anomalies—David R. Harrington and Herbert M. Stauffer, Temple University Hospital, Philadelphia.

Anomalies of the aortic arch are not rare. Many are clinically significant, roentgenologically demonstrable, and amenable to surgery. Examples of the commoner ones will be shown together with their embryology and clinical history.

S-416. Pennsylvania Heart Association, Inc.

This exhibit will show the organization and purpose of the Pennsylvania Heart Association. A diagrammatic presentation will be given of the association's program in research, education, and community service. The various educational pamphlets that are available through the association will be on display.

S-417. Pubic and Ischial Necrosis Following Pelvic Surgery (Osteitis Pubis)—Edwin L. Lame and Hon Chon Chang, Presbyterian Hospital, Philadelphia.

Pubic and ischial destruction occurs uncommonly two to twelve weeks postoperatively in prostatectomies especially and in other pelvic disease very rarely. The diagnosis is made clear by history, physical signs, and roentgen signs. The course of the disease is like low-grade osteomyelitis; it is self-limited. The cause is unknown. Biopsies have been few and incomplete, but imply that infection is a cause. Trauma to arteries and veins has not been investigated and may be important. Individual susceptibility to infection under the usual trauma and failure to diagnose mild cases may explain the rarity of reported cases. Isolated groups respond to certain methods of treatment. Roentgen therapy causes prompt partial relief, but does not shorten total duration.

S-418. Graduate Education Institute—Commission on Graduate Education, The Medical Society of the State of Pennsylvania.

S-419. Gastroscopic Biopsy—Paul L. Shallenberger, Charles H. Dewan, Clayton B. Weed, and John C. Regan, Guthrie Clinic, Robert Packer Hospital, Sayre.

Gastroscopic biopsies through the flexible tube gastroscope were introduced by Benedict in June, 1949. The authors have examined about 75 cases including biopsy. This represents many forms of pathology and also normal stomachs. Pathologic entities included are normal stomachs, various types of gastritis, gastric ulcer, gastric polyps, gastric diverticulum, Borrmann classes of all kinds of carcinoma, polycythemia vera, and lymphosarcoma. This represents a wide study of the gastric mucosa under controlled conditions and without the usual postmortem or post-surgical enzymatic effect on the mucosa. The exhibit will consist of x-rays, kodachrome enlargements of gross specimens removed at surgery, and photomicrographs of representative tissue specimens of the different types of pathology described. The purpose of the exhibit is a preliminary report on this new method of diagnosis of

gastric pathology. The conclusions are that it is an improvement over our present methods. By adding the objective evidence of the tissue, a positive diagnosis of malignancy is absolute. The exhibit will also point out the difficulty remaining with such problems as the gastric ulcer—is it benign or malignant? Small localized areas of pathology are difficult technically to biopsy.

S-428. Progress in the Control of Diabetes—Howard F. Root, Elliott P. Joslin, Priscilla White, Alexander Marble, and Allen P. Joslin, George F. Baker Clinic, New England Deaconess Hospital, Boston, and Donald B. Armstrong and Herbert H. Marks, Metropolitan Life Insurance Company, New York.

Charts will be shown presenting clinical and statistical data on (1) treatment of diabetes and its major complications, juvenile diabetes and diabetic pregnancies, with emphasis on careful dietary and insulin treatment in the control of diabetes; (2) results of treatment of the disease based on follow-up data of diabetic patients treated at the George F. Baker Clinic, New England Deaconess Hospital, since 1897; (3) life tables for diabetics showing the progressive increase in expectation of life, comparisons with the general population, and factors influencing the longevity of diabetics; (4) trends in the causes of death of diabetics;

and (5) trends and prevalence of diabetes in the general population based on mortality and survey data.

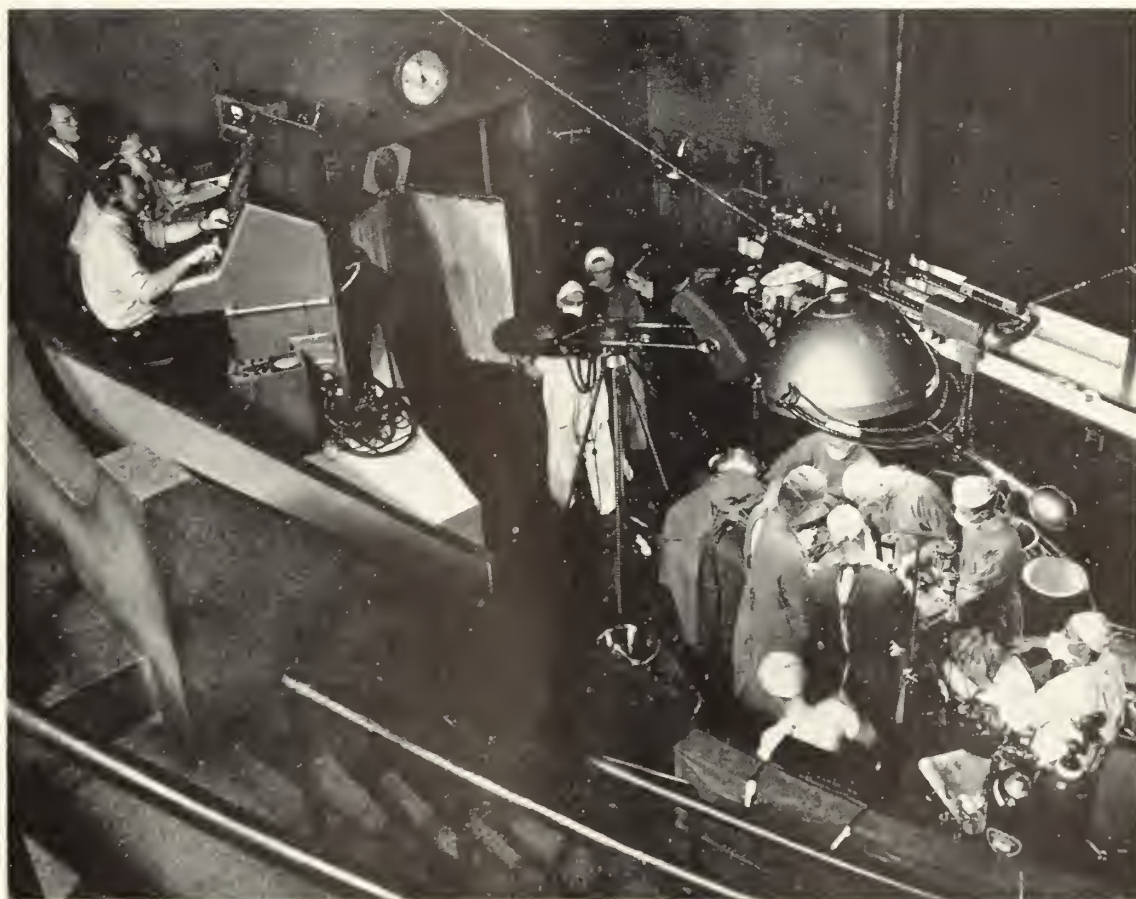
S-429. Treatment of Complications of Diabetes Mellitus—Commission on Diabetes, The Medical Society of the State of Pennsylvania.

The exhibit will stress the prevention, detection, and treatment of the major complications of diabetes such as acidosis, insulin shock, arteriosclerosis, retinitis, and renal disease. The purpose of the exhibit is to familiarize those attending the session with the complications of diabetes and show that many of these complications can be prevented or their severity minimized by early detection.

S-430. New Tests for Pulmonary Function—Julius H. Comroe, Jr., and W. S. Fowler, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

This exhibit will demonstrate a new test of pulmonary function which, during a single respiratory cycle, measures the distribution of inspired O₂ among the pulmonary alveoli. Since a complete test requires only a minute, it can be performed on any physician interested in the test. Its applicability to mass testing in industry will be demonstrated.

S-431. The Mediastinum in Infancy—John M. Higgins, S. Paul Perry, Dominic S. Motsay, and Wayne



Color television will play an important role at the 100th Annual Session in Philadelphia. Surgical and clinical procedures performed in the Hospital of the University of Pennsylvania will be shown Monday through Wednesday, October 16 to 18, by a direct telecast to Convention Hall. Shown above is an operation being photographed by a color television camera.

H. Allen, Guthrie Clinic, Robert Packer Hospital, Sayre.

Much controversy exists concerning the relationship of thymic enlargement to symptoms of respiratory distress, and even sudden death. An effort is made in this exhibit to determine by x-ray examination of the newborn infant's chest if symptoms of dyspnea, cyanosis, or disturbances of respiratory rate can be attributed to an apparently enlarged thymus gland. Approximately 1000 consecutive newborn infants have been studied by x-ray during the first six days of life. The width of the mediastinum at the level of the bifurcation of the trachea was measured and note made of the presence or absence of respiratory symptoms. From three to nine months later, all infants who had respiratory symptoms during the first six days of life or who had unusual mediastinal shadows were re-evaluated both by x-ray and by general examination. Anteroposterior views were taken in all cases and frequently lateral views. Because of difficulties in technique, lateral views have not been uniformly satisfactory.

In a number of instances, definite enlargement of the thymus was indicated by the so-called "sail shadow," which is described in the literature. In some instances this finding has been associated with wheezing, cyanosis, or irregularity of the respiratory rate. Careful study of the cases with symptoms has usually indicated an underlying pathology other than the thymic enlargement.

The question as to the role played by the enlargement of the thymus in the production of respiratory symptoms and/or sudden death has not been solved by this study, but the impression gained indicates that while apparent enlargement of the thymus frequently is present in the newborn, as shown by x-ray, careful evaluation of the patient often reveals a cause for the symptoms to be on another basis.

S-432. Prognosis of the Patient with Bronchiectasis—W. Emory Burnett, George P. Rosemond, Joan Humphrey Long, and John H. Hall, Temple University School of Medicine, Philadelphia.

This study, designed to demonstrate the prognosis of bronchiectasis with and without surgery, covers more than 200 cases of resections of portions of the lung, of which it has been possible to follow the course of approximately 150 cases.

The exhibit will be divided into three sections. The first will illustrate the curative treatment of bronchiectasis and demonstrate, by placards and slides, the type of patient with bronchiectasis who can be cured of all disease and symptoms and most completely rehabilitated by surgery.

The second small section will demonstrate the palliative surgical treatment of bronchiectasis and will show the type of patient in whom symptoms are usually alleviated but not necessarily completely relieved.

In the third section an attempt will be made to demonstrate the type of patient in the exhibitors' group of cases who has responded poorly to surgery.

S-433. Plastic Surgery of the Nose and Face—Albert P. Seltzer, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

The complete technique in nasoplastic surgery and face lift, including basic principles, demonstrated by

clear illustrations, starting from the selection of instruments, anesthetic, and step-by-step procedure to the postsurgical result, will be presented. Displayed will be the anatomy of the nose together with the technique in the use of instruments (original). New instruments such as a nasal clamp, plexiglass nasal mold, gauze, and electric saw guide will be presented with descriptions by photographs. Each aspect will be well illustrated with original drawings, thus giving a practical application of coordinating anatomy, physiology, and surgery. Elimination of fixity of facial expression, grafts and their preparation, and the unsuccessful operation—its causes and prevention—will also be shown. An animated kodachrome motion picture which is utilized in the teaching of plastic surgery at the Graduate School of Medicine of the University of Pennsylvania will be presented.

S-434. Prize-Winning Posters — 1950 State-wide Poster Contest, The Medical Society of the State of Pennsylvania.

S-435. "Benemid," a Compound Influencing Metabolism of Penicillin and Para-aminosalicylic Acid (PAS)—William P. Boger, Walter V. Matteucci, and Harrison F. Flippin, Philadelphia General Hospital, Philadelphia.

This exhibit will present the first clinical studies of a new compound that holds the promise of extending the clinical use of oral penicillin particularly and increasing the effectiveness of para-aminosalicylic acid (PAS) in the treatment of human tuberculosis.

The new compound, p-(di-n-propylsulfamyl)-benzoic acid, "Benemid," has been found to increase the plasma concentrations of penicillin and para-aminosalicylic acid by 2- to 4-fold. This drug influences the metabolism of certain organic acids that are administered therapeutically. The conjugation of these organic acids with glycine is inhibited by "Benemid." The enzymes responsible for the conjugation are related to the excretory mechanisms whereby penicillin, phenolsulfonphthalein (PSP), and para-aminohippuric acid (PAH) are excreted. The mode of action and the effects of "Benemid" on various drugs, including streptomycin, aureomycin, chloromycetin, and terramycin will be shown.

S-436. Anthracosilicosis—Hurley L. Motley, Burgess Gordon, Peter A. Theodos, Leonard P. Lang, and Joseph F. Tomashefski, Jefferson Medical College Hospital, Philadelphia.

The exhibit will consist of charts, roentgenograms, and photographs operated mechanically. These demonstrate the disturbances of respiration and circulation in pulmonary fibrosis and emphysema associated with silicosis, bronchiectasis, tuberculosis, and long-standing congestion due to heart disease. The mechanism of alveolar function in normal and diseased lungs will be demonstrated with animated devices. Physiologic quantitative measurements of ventilation (vital capacity, maximal breathing capacity, and minute volume of air breathed), pulmonary emphysema (degree based on residual air per cent of total lung volume), and respiratory gas exchange (including arterial blood studies and analysis of expired air) provide information which is useful in the more exact diagnosis of pulmonary dis-

ability. The clinical and physiologic basis for treatment with intermittent positive pressure breathing combined with the simultaneous use of bronchodilator and wetting agents as aerosols will be presented.

S-437. Keystones of Public Health for Pennsylvania—Commission on Preventive Medicine and Public Health, The Medical Society of the State of Pennsylvania.

S-510. Physical Medicine and Rehabilitation as Applied to Local Community Agencies, Schools, and Hospitals—Commission on Physical Medicine and Rehabilitation, The Medical Society of the State of Pennsylvania.

The purpose of this exhibit is to clearly set forth the various methods employed in the rehabilitation of the handicapped person in all stages and in all conditions. It is pertinent to show the steps necessary in the re-training of the disabled person and the handicapped child in the self-care required for daily activities.

Rehabilitation procedures as applied to the handicapped child as well as to the geriatric patient will be shown with the coordination of the services provided by various agencies which achieve rehabilitation through their facilities for pre-vocational and vocational training and placement services. Rehabilitation as offered by special schools to the orthopedically handicapped child as well as the child with multiple handicaps will be graphically shown and services provided to the convalescent patient and the home-bound patient will be clearly demonstrated.

Guidance and counseling service as related to the personal, family, or psychiatric problems of the handicapped person will form an important part of the exhibit. The methods of the vocational counselor in regard to the vocational adjustment of the handicapped and the selection of a vocation will take their place in this part of the exhibit to show the relation of the social case worker to the rehabilitation program. This is an important part of rehabilitation and must be clearly set forth, as it will be in this exhibit, because the most important phase of rehabilitation to the handicapped person is his appropriate placement in congenial and remunerative employment. The sheltered workshop will be demonstrated as well as employment for the home-bound patient.

S-511. Pain Control—Diagnosis and Therapy—Bernard D. Judovich, William Bates, Joseph C. Yaskin, and Robert A. Groff, Graduate Hospital, University of Pennsylvania, Philadelphia.

This exhibit will present somatic pain syndromes, especially those of the radiating and reflex types. Because of projecting pain, therapy is frequently and erroneously applied to areas far removed from the actual source of irritation. As a result, treatment fails to provide relief of pain.

A presentation of syndromes will include the cervical disk, scalenus anticus syndrome, occipital neuralgia, intercostal neuralgia of the chest and abdominal walls, low back pain with and without radiation to the lower extremity. Brachial plexus neuralgia and sciatic pain will be presented with detailed etiologic factors and diagnostic procedures. It is emphasized that the pain

syndromes are merely symptoms and not specific diseases.

A clinical concept of skeletal pain will be presented which can be applied to the examination of the patient. This has a direct bearing on localizing the source of pain for purposes of diagnosis and therapy.

Two manikins will be displayed—one showing step-by-step technique of nerve block, the other for actual practice with electrical registration showing nerves contacted and their distribution.

S-513. Lead Poisoning in Children—Horst A. Agerty, Ronald M. Bernardin, and William C. Foster, Hahnemann Hospital, Philadelphia.

Lead poisoning is still an actual hazard to infants and children, chiefly because of the habit of pica and gnawing on painted surfaces. A detailed study and follow-up report will be presented on a series of 8 cases of lead poisoning in children seen on the pediatric wards of Hahnemann Hospital in the past 18 months. The studies included: (1) quantitative blood and urine lead analyses; (2) analysis of the lead content of the painted surfaces which were the source of the poisoning; (3) study of neurologic changes including spinal fluid and electro-encephalographic findings; (4) study of response to sodium citrate therapy; (5) follow-up of these cases with emphasis on evaluating the amount of permanent central nervous system damage and alteration in growth and development.

Lead poisoning is not an uncommon disease and the possibility of its presence should be considered wherever there is a history of pica, especially when associated with the presence of anemia, irritability, or convulsions. The definitive diagnosis rests on basophilic stippling of red blood cells, roentgenographic demonstration of heavy metal deposit in bones, and abnormal level of lead in blood and urine. Lead poisoning is a disease which is fraught with serious and often permanent central nervous system damage. Effective therapy consists of removal of source, control of convulsions, and transforming the circulating ionized lead into a poorly dissociated lead citrate complex and excretion of such via the urine.

S-515. Surgical Lesions of the Brain and Spinal Cord—Francis C. Grant, Hospital of the University of Pennsylvania, Philadelphia.

This exhibit will consist of 200 or more colored lantern slides of operative fields carefully grouped to show the different types of tumors and traumatic lesions involving the brain and spinal cord.

S-517. Isolation of Pleuropneumonia-like Organisms—Harry E. Morton, University of Pennsylvania School of Medicine, Philadelphia.

A new culture medium has been formulated by the authors which enables the pleuropneumonia-like organism to be cultivated more readily from clinical material. The description of the culture medium has been submitted for publication, but may not appear in print before October 15. By employing the medium and methods which will be demonstrated, the pleuropneumonia-like organisms are frequently isolated from infectious processes in man. Data obtained by the authors and other workers indicate that these organisms play a definite role as etiologic agents of infectious processes in

man. Methods for collecting material from patients, and culturing and identifying the organisms will be demonstrated.

S-519. Diseases of the Vulva—Clinical and Laboratory Diagnosis—Carmen C. Thomas, Woman's Medical College of Pennsylvania and Philadelphia General Hospital, Philadelphia.

By means of black and white transparencies, various common vulvar diseases and their histopathologic or other laboratory means of diagnosis (e.g., fungus culture preparations, Donovan bodies, etc.) will be illustrated. Treatment will not be included in this presentation.

The exhibit will include the following entities: simple inflammatory processes—fungus infections, psoriasis, lichen planus, and drug sensitivity; atrophic lesions—kraurosis and leukoplakia; granulomas—primary and secondary syphilis, chancroid, granuloma inguinale, tuberculosis, and verrucae; neoplasms—Bowen's disease and carcinoma.

S-529. Commission on Cancer, The Medical Society of the State of Pennsylvania.

S-531. Newer Aids in Cancer Diagnosis—Mildred C. J. Pfeiffer, Oncology Department, Woman's Medical College of Pennsylvania, Philadelphia.

This exhibit will provide an illustrated summary of current aids in cancer diagnosis. By means of charts, photomicrographs, and other transparencies, and actual equipment of instruments, attention will be directed to such aids as Papanicolaou smears, gelfoam biopsies, gastroscopic and aspiration biopsies, hormonal studies, serodiagnostic attempts, etc. An attempt will be made to submit proof of earlier diagnosis of cancer in situ, for example, by means of the Papanicolaou smear, routine chest x-ray, etc., as facilitating earlier diagnosis. By so doing, it is hoped that the practitioner will conclude the following: that in addition to a good history and complete examination, even in the absence of symptoms, office procedures can be augmented by additional laboratory or hospital studies which will lead to earlier and more accurate diagnosis of cancer and thereby to earlier treatment, resulting in demonstrably longer survival of patients.

S-532. The Hip Joint—Mary Frances Vastine, Mary Helen Cameron, and Jacob H. Vastine, Woman's Medical College Hospital, Philadelphia.

Roentgenograms will demonstrate all the pathologic conditions except fractures which occur in the hip joint. Monographs describing each film will be available.

S-533. Congenital Foot Deformities—Leonard F. Bush and Willard H. Love, Jr., Geisinger Memorial Hospital and Clinic, Danville.

The purpose of this exhibit is to illustrate in a graphic way the common congenital foot deformities including chiefly calcaneovalgus, metatarsus varus, and equinovarus feet. The various types of treatment for these conditions will be emphasized by illustration as will the end results. Some of the other foot deformities that might be encountered will likewise be shown together with the technique of plaster cast application as used in this clinic.

This exhibit is particularly planned to stress the importance of early diagnosis and treatment of congenital deformities of the foot in babies, and should prove of interest to the general practitioner, the obstetrician, the pediatrician, and any others who treat infants and children.

The exhibit will consist chiefly of transparencies with a small amount of printed matter.

S-534. A New Test for Vasopressor Substances in Hypertension and Eclampsia—David B. Fishback, Jewish Hospital, Philadelphia.

By performing blood tests on patients with normal blood pressure, hypertension, early eclampsia, etc., the presence of excessive vasopressor substances is determined. Correlation of the facts is then attempted in the hope of diagnosing pre-hypertensives and preeclampsics. The test calls for the injection of 3 cc. of human blood serum into the ear vein of a rabbit and the determination of the animal's circulation time by a fluorescein method. It has been determined that a circulation time of less than 7.5 seconds is normal; a longer period is abnormal. The blood serum from hypertensive, pre-eclamptic, and eclamptic patients usually prolongs the circulation time in the rabbit. The increase in the time is probably caused by the presence of excessive vasopressor substances in the serum producing a peripheral vasoconstriction in the rabbit. Studies are being made in cases of pheochromocytoma and in placid and violent mental cases. Patients who have had a dorsolumbar sympathectomy performed have also been tested. This test was suggested by a previous experiment in which adrenalin and pituitrin markedly prolonged the fluorescein circulation time in rabbits.

S-535. Anatomic Prostheses—Dale Sittman, Allegheny General Hospital, Pittsburgh.

This is an exhibit of life-like soft resin anatomic prostheses comprised of noses, ears, eyes, fingers, and maxillofacial replacements, as well as various types of acrylic stents and implants, with mouldages and photographs of preoperative cases and results obtained post-operatively.

S-536. A Study of the Golgi Material and Mitochondria in Neoplasms of the Kidney, Urinary Bladder, and Prostate—Albert E. Bothe, A. J. Dalton, and Frederick O. Zillesen, Jeanes Hospital, Philadelphia, and the National Cancer Institute, Bethesda, Md.

This exhibit will show the results of a cytologic study involving the Golgi material and mitochondria in human tissues from kidney, urinary bladder, and prostate. Insofar as the investigators know, this is the first time such an investigation has been undertaken involving human material. The study has revealed a striking difference in the Golgi material and mitochondria as seen in the benign lesion contrasted with the malignant lesion.

S-537. Cancer of the Lung—Charles S. Cameron, American Cancer Society, Philadelphia Division.

This exhibit will show comparative statistics on the relationship of lung cancer at all sites prior to 1900 to the present death rates of cancer of the lung. An analysis of endogenous and exogenous factors and their causal relationship to cancer of the lung will be made.

DANGEROUS DRUG ACT

Act 407 of the 1935 Session of the Pennsylvania Legislature is the Dangerous Drug Act.

Section 2 reads as follows:

"No hypnotic drug or analgesic or body-weight reduction drug, as defined herein, shall be sold at retail or dispensed to any person except upon the written prescription of a duly licensed physician, dentist, or veterinarian."

The signing of the prescription should be done by the physician himself.

"Regulation No. 1 promulgated under the Dangerous Drug Act requires a new prescription for each refill in excess of the number of refills specifically authorized by the original prescription."

The State Department of Justice has released an opinion using the following:

"... before a pharmacist may lawfully sell or dispense any analgesic, hypnotic, or body-weight reduction drug, ... whether it be by original prescription or by renewal, he must be in actual possession of a written prescription personally prepared and signed by a duly licensed physician, dentist, or veterinarian. Such prescription may be written by an assistant provided that it is verified by the signature of the practitioner."

The current diagnostic procedures for cancer of the lung with notes on their varying efficacy will be outlined, and the indications for surgery and survival rates from pneumonectomy will be given.

S-538. Gastric Biopsy with the Operating Gastroscope—C. Wilmer Wirts, Robert L. Breckenridge, Stuart D. Kusterman, and Donald M. Wald, Jefferson Hospital and Philadelphia General Hospital, Philadelphia.

This exhibit will illustrate our experience in gastric biopsy with the operating gastroscopic at Jefferson Hospital and Philadelphia General Hospital. Ever since the introduction of the standard flexible gastroscopic in 1932, investigators have attempted to modify it to permit gastric biopsy, but it was only during the past year that a satisfactory instrument for this purpose was made available by the American Cystoscope Makers, Inc.

Twenty-four colored transparencies will be shown, correlating the gastroscopic, roentgen, biopsy and the gross surgical or necropsy specimen in the patients examined. Examples of the findings in normal stomachs and in those with gastritis, ulcer, carcinoma, sarcoma, carcinoid, diverticulum, and polyp will be demonstrated. The technique we employ both for standard flexible tube gastroscopy and for biopsy with the operating gastroscopic will be outlined. Our findings in more than

300 biopsies performed in 150 patients will be summarized.

S-540. Lesions of the Thyroid Gland—Frederick A. Bothe, Richard H. Driscoll, and John A. Fust, Presbyterian Hospital, Philadelphia.

A series of transparencies will depict the histologic picture in (1) diffuse toxic goiter, the effect of iodine, thiouracil, and propylthiouracil showing a pattern simulating carcinoma, (2) types of chronic thyroiditis, (3) adenomas, (4) carcinomas, and (5) non-toxic goiter and sarcoma.

S-542. Meckel's Diverticulum—Thomas A. Shallow, Sherman A. Eger, and Frederick B. Wagner, Jr., Jefferson Medical College and Hospital, Philadelphia.

This exhibit will illustrate the varying clinical manifestations of Meckel's diverticulum, the difficulties in diagnosis, and the problems in treatment from a series of 75 cases. It will be shown that the grave complications frequently associated with Meckel's diverticulum transform its role from a mere surgical curiosity to one of importance in both acute abdominal emergencies and elective laparotomies. Incidental search for Meckel's diverticulum at laparotomy should be just as routine as for the appendix. If the diverticulum is found, it should be removed whenever possible, for it is a potential source of danger which can be eliminated with no appreciable risk.

S-544. Diagnostic Aids and Bulbar Poliomyelitis—National Foundation for Infantile Paralysis, New York City.

Some of the critical signs of acute anterior poliomyelitis and the histopathology of bulbar poliomyelitis and its clinical syndromes will be depicted in this exhibit. Suggested methods of therapeutics for cranial nerve nuclei, respiratory center, circulatory center, encephalitic and combined bulbar-spinal involvements will be shown.

YOUR CONVENTION TELEPHONE NUMBER

Your emergency telephone numbers for receiving calls while attending the 100th Annual Session of The Medical Society of the State of Pennsylvania will be:

Convention Hall—Evergreen 2-2129

**Bellevue-Stratford Hotel — Pennypacker 5-0700,
Extension 107**

Leave word with those in your office that you convention hours in case you are needed in an can be reached through these numbers during emergency.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

"Cancer of the Lung"

The monograph "Cancer of the Lung" is described by John V. Foster, M.D., of Harrisburg, specialist in pulmonary diseases, as a "must on the reading list of every physician and a few minutes well spent."

"Cancer of the Lung" was written by Richard H. Overholt, M.D., clinical professor of surgery at Tufts College Medical School and surgical staff member of the New England Deaconess and New England Center Hospitals in Boston, and Sherman W. Atwell, fellow in research, Overholt Thoracic Clinic. It was published by the American Cancer Society and has been distributed by the Pennsylvania Division of the society to most physicians in the Commonwealth.

Dr. Foster said:

"In this article the authors emphasize the importance of survey films in the asymptomatic general population, and that no physical examination is complete without an x-ray. Dr. Overholt emphasizes the importance of prompt and proper evaluation of abnormalities found, especially of those in men over 40 years of age, and the importance of bronchoscopy and cytologic study in all cases of suspected neoplasm.

"One cannot overemphasize the importance of early surgical exploration in suspected cases, since the mortality is only 1 per cent. In their clinic 40 per cent of all cases explored under a diagnosis of tumor suspect have proved to be cancer. The remainder were benign tumors, tuberculomas, and other abnormalities warranting excision."

Dr. Overholt will be a guest speaker on the scientific program at the one hundredth annual session of The Medical Society of the State of Pennsylvania. He will speak in Convention Hall at 9:40 a.m., Tuesday, October 17, on "Benefits of Surgery in Pulmonary Tuberculosis."

New Exhibit

"Cancer of the Lung," the American Cancer Society's newest exhibit for physicians, is available for loan to state professional meetings through the Pennsylvania Division of the society, Hall Building, Harrisburg.

This is the second of a series of exhibits for physicians on various phases of cancer which will be constructed during the next few years. It is 20 feet in length and contains four main panels, one each on statistics, epidemiology, diagnosis, and treatment of lung cancer. A left and right-hand panel are attached which contain pertinent questions and a summary of important points on lung cancer.

The exhibit has been reserved for showings at the American Hospital Association in Atlantic City, September 18-21; at the scientific assembly of the District of Columbia Medical Society, October 2-4; at The Medical Society of the State of Pennsylvania annual convention October 15-19 in Philadelphia; and at the American College of Surgeons annual meeting October 23-27 in Boston.

* * *

Dr. C. C. Little, director of the Roscoe B. Jackson Memorial Laboratory at Bar Harbor, Maine, will receive the American Cancer Society's annual award for outstanding contributions to cancer control. The award will be made at the annual meeting of members of the society in October.

* * *

Directors of the American Cancer Society have approved a request from the Commission on Chronic Illness for a grant of \$10,000 in support of the commission's program for the year Oct. 1, 1950, to Sept. 30, 1951.

The directors also granted \$2,500 to the National Hospital for Speech Disorders of New York City to defray part of the expenses of the Post-Laryngectomy Clinic of that hospital.

* * *

The American Cancer Society has decided, through its board of directors, to support formation of a committee of the National Research Council that will investigate alleged cancer cures and cancer tests.

The society will underwrite a fair share of the committee's budget. The National Cancer Institute and the American Medical Association have indicated interest in and approval of the committee and probable willingness to participate in its financial support.



OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D.,

Secretary-Treasurer



Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

PROCUREMENT AND ASSIGNMENT ACTIVATED

WESTERN UNION

Day Letter

Pittsburgh, Aug. 18, 1950.

*To County Medical Society Presidents and
Secretaries:*

Please name chairman of your county society's Committee on Procurement and Assignment not later than August 28. He may be a veteran not in military reserve or physically disqualified for service or aged over fifty. Our state society Committee on Procurement and Assignment* authorized July 28 and activated August 14 has been unexpectedly mandated by U. S. Army authorities to pass on the first group of fifty-five Pennsylvania doctors who must report for service on September 10.

This requires county society participation, hence this request for quick selection of your chairman.

Send his name to M. C. Stayer, M.D., Chairman, Procurement and Assignment Committee, 230 State St., Harrisburg, Pa.

WALTER F. DONALDSON,
Secretary-Treasurer.

Progress Report of State Society's Committee on Procurement and Assignment of Medical Officers, Aug. 19, 1950

The chairman of the State Society's Committee on Procurement and Assignment of Medical Officers, Dr. Morrison C. Stayer, and Dr. James Z. Appel, councilor for the Fifth District, represented the Society at a meeting on Aug. 17, 1950, with Colonel H. W. Glattly, Surgeon,

Headquarters Second Army, Fort George G. Meade, Maryland.

Other state societies represented at this meeting were Kentucky, West Virginia, Virginia, and Ohio.

General Orientation

Colonel Glattly reviewed the need for medical and dental officers to provide adequate service to the Armed Forces during the present emergency and emphasized the following:

1. Although there is strong sentiment among professional societies that the ASTP and V-12 students should be called to active duty before reserve officers, it is impossible for the Surgeon General to do so in view of the lack of legislation. The Surgeon General is in no position to bring pressure to bear upon Congress. This pressure must come from the professional societies themselves.
2. Many efforts have been made to obtain volunteers through thousands of letters to reserve officers and professional societies. Although some efforts have been fruitful, results have been very limited to date.
3. Reserve officers are currently being called to active duty on a non-voluntary basis. The initial officer quota for the entire United States totals 754 physicians, 343 dentists, and 50 veterinarians. All of these officers must be on duty prior to the first of October, 1950.
 - a. *Volunteers will be credited against these quotas.*
 - b. The quotas for recall of these professional officers have been allocated to the six Continental Army Areas on the basis of populations of professional personnel, not on area reserve officer strengths.

* Morrison C. Stayer, Carlisle, *Chairman.*
Paul G. Bovard, Tarentum.
Gilson Colby Engel, Philadelphia.
Frank R. Hanlon, Wilkes-Barre.
Lloyd E. Wurster, Williamsport.

- c. Reserve officers recalled to duty, either voluntarily or involuntarily, will be recalled in their present reserve grade.
 4. The \$100 additional pay authorized to physicians and dentists under Public Law No. 365 can be paid only to volunteers and not to those involuntarily recalled.
 - a. Those officers presently members of active reserve components or National Guard may volunteer even though their unit has been alerted. This will qualify them for the extra \$100 pay each month. They may, at the time they volunteer, request assignment to the unit of which they are presently a member. These volunteers will, however, not be credited against quotas.
 5. Delays in calling some officers into service will be extended generally to five categories:
 - a. Medical officers who have not completed one year of internship training.
 - b. Senior residents until the completion of their current year's training.
 - c. Professional officers enrolled in post-graduate courses within their respective fields at recognized schools until completion of their current academic year.
 - d. Professional officers with essential roles in teaching, research, and allied endeavors.
 - e. Professional officers whose departure would jeopardize the health of their communities.
 6. Reserve medical officers presently living in Pennsylvania total 1031. The breakdown is as follows: lieutenant colonels, 305; majors, 423; captains, 250; lieutenants, 53. The quota for the Pennsylvania Military District on this call is 55. No breakdown as to military occupational specialty (MOS) or rank is presently available.
 7. The following plan is suggested for State Society Committees on Procurement and Assignment:
 - a. Organize a committee of not less than three members of the State Society.
 - b. Contact and continue to remain in contact with Pennsylvania Military District office, which is located at 2620 Gray's Ferry Road, Philadelphia 46, Pa. The commanding officer is Colonel Hobart A. Murphy.
- (1) Colonel Murphy will receive from Colonel Glatly of the Second Army the quotas of officers desired by MOS. Colonel Murphy will then forward to the State Society's Committee Information Forms No. 8-130 on all reserve officers.
 - (2) These forms should be reviewed by our committee and numbered in the order in which they are to be called to active duty.
 - (3) The Pennsylvania Military District office will then issue orders to those indicated for active duty and have them report for a final-type physical examination. *Following the physical examination, the officer will then revert to inactive status.*
 - (4) Officers' Physical Examination Forms and Information Forms will then be sent to Colonel Glatly, who must forward them in time to arrive in Army Headquarters, Washington, D. C., not later than noon, Sept. 10, 1950.
 - (5) All final active duty orders will originate in the Surgeon General's Office, Washington, D. C. Therefore, it is suggested that individual officers should not dispose of business, etc., until after their final-type physical examination and until after they have received final notification from the Surgeon General's Office to report for active duty.
- Note:* Active duty orders may be delayed for quite some time because the Army is making every effort to eliminate assignment of medical officers prior to the time for their actual need.
- (6) It is suggested that our Committee on Procurement and Assignment devise ways and means to check and double-check MOS numbers, in order that records may be accurate in the designation

of these individuals for assignment.

(a) The Second Army has made continuous efforts to have officers submit Information Forms. However, cooperation has been exceedingly poor in this respect and records are not presently up-to-date.

(7) Any differences of opinion between the Medical Society's Committee and the Pennsylvania Military District should be referred directly to Colonel Glattly, Second Army, for his information and clarification.

8. Volunteer telegrams sent by officers who wish to volunteer should be directed to the Commanding Officer, Pennsylvania Military District, Schuylkill Arsenal, 2620 Gray's Ferry Road, Philadelphia 46, Pa.
9. It is indicated that this will not be the final call for reserve officers but is only the beginning. Therefore, the system which is presently being worked out, even though it is a small number of officers, should be looked upon as the system to be used hereafter in fulfilling quotas.
10. The following suggestions were made in regard to procurement of reserve officers, in addition to those appearing under Paragraph No. 5:
 - a. Previous military service other than that in the capacity of a medical officer should not be considered as a qualification for deferment.
 - b. Some medical officers who received training in the ASTP are presently in the Reserve Corps. Most of these have served two years since the end of World War II. These may be considered as a source of supply.
 - c. The Surgeon General's Office has available a list of all ASTP men. This list is not up-to-date, but will be furnished to our State Society as quickly as possible.
 - d. It is suggested that, whatever plan is arrived at in our State Society, it be directed to the attention of the Selective Service Officer in Pennsylvania, so that he may have it available when leg-

islation is completed by the Federal Congress.

11. The criteria for the induction of reserve officers is left solely in the hands of our Committees on Procurement and Assignment and they may alter, as they see fit, any suggestions made heretofore in this report.
12. The information contained in this report is subject to revision and may be superseded at any time by the United States Army Surgeon General.

MORRISON C. STAYER, *Chairman*

PAUL G. BOVARD

GILSON COLBY ENGEL

FRANK R. HANLON

LLOYD E. WURSTER

ROBERT L. RICHARDS, *Staff Secretary*

AMERICAN MEDICAL ASSOCIATION PRESIDENTIAL OATH OF OFFICE

I solemnly swear that I shall carry out the duties of the office of President of the American Medical Association to the best of my ability. I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to the task of bringing increasingly improved medical care within the reach of every citizen. I shall uphold the Constitution of the United States and the Constitution and By-laws of the American Medical Association at all times. I shall champion the cause of freedom in medical practice—and freedom for all my fellow Americans.

I do solemnly swear that I will discharge the duties of this office to the best of my ability, so help me God.

ARMY MEDICAL CORPS FACTS

Published below is a set of questions and answers about the involuntary recall of any medical officers issued by the Surgeon General of the Army on August 17. These questions and answers were prepared and released following the announcement that the Army would call 734 reserve medical officers to active duty.

These questions and answers summarize the situation at the end of August. However, by the time this material appears in print, some of the policies will have changed either by Army directives or legislation.

1. Q. *Is a National Guard or Army reserve officer or enlisted man who is a pre-medical student eligible for delay under the policy of the Department of Defense?*
 - A. Under announced policies of the Department of Defense, call to active duty of a member of the civilian components enrolled in an educational institute may be initially delayed until completion of the school term in which the member is then registered. At the end of the initial specified delay, extension of delay may be requested. The established policy does not permit blanket deferments. Each individual case must be considered and acted upon separately.
2. Q. *Is the pre-medical student who is not a member of the reserve or National Guard eligible for deferment from the draft?*
 - A. Announcements of policy by the National Headquarters, Selective Service System, should be consulted in connection with this question. The National Headquarters, Selective Service System, issued on Nov. 2, 1948, Local Board Memorandum No. 7, Subject: "Students of Healing Arts." Provisions are contained therein for deferment of certain pre-professional students (including medical) who have successfully completed at least one year of pre-professional study and have been provisionally accepted for entrance into the professional school.
3. Q. *Is a National Guard or Army reserve officer or enlisted man who is a medical student or intern eligible for delay from call to active duty?*
 - A. Graduates of advanced course senior division ROTC and members of civilian components enrolled, or who have been accepted for admission, in a recognized school of medicine will be delayed in call to active duty until the end of the fall quarter or semester of their college or university. At the end of the initial specified delay, extension may be requested. Members of civilian components who have not completed at least one year of intern training will also be granted delay in call until completion of one year's internship.
4. Q. *Is a medical student, intern, or resident who is not a member of the reserve or National Guard eligible for deferment from the draft?*
 - A. Announcements of policy by the National Headquarters, Selective Service System, should be consulted in connection with this question also. Provisions for permitting students who are not otherwise deferrable under the Selective Service Act of 1948, as amended, and who are properly enrolled in certain professional schools (including schools of medicine) and satisfactorily pursuing full-time courses leading to graduation, to continue their studies until graduation, are contained in Local Board Memorandum No. 7.
5. Q. *Is a National Guard or Army reserve officer or enlisted man who is in residency training eligible for delay?*
 - A. Only those in the last year of their residency are eligible for initial delay. Enlisted men of the civilian components in this category are urged to apply for appointment in the Medical Corps Section of the Officers' Reserve Corps under the provisions of Department of the Army Circular 210 of 1948, or to the State Adjutant General of the state of their residence, for appointment as a medical officer in the National Guard.
6. Q. *What action should be taken by interns and residents who are members of line organizations in the National Guard or Reserve?*
 - A. Those officers of the Reserve who are qualified for transfer to any one of the Corps of the Army Medical Service Reserve may submit a request for transfer under the provisions of SR 140-160-1. Such request should be submitted through appropriate Reserve channels to the Commanding General of the Army in whose area they reside. Individuals enlisted in the Reserve who are qualified for appointment in any one of the Corps of the Army Medical Service Reserve may apply for appointment under the provisions of Department of the Army Circular 210 of 1948. Medical students enlisted or commissioned in the National Guard are under the jurisdiction of the State Adjutant General concerned prior to their induction. Requests for determination of status, commissioning or transfer to the Medical Corps, and granting of any delay in call to duty of such individuals should be directed to the State Adjutant General concerned.
7. Q. *What obligation is incurred by an individual accepting a delay or deferment?*
 - A. No additional obligation is incurred by reason of acceptance of a delay in call to duty or deferment. Upon termination of such delay or deferment the individual is subject to call to active duty on the same basis and under the same procedures as he would have been initially called.
8. Q. *What other individual Reserve or National Guard medical officers are eligible for consideration for delay from call to duty?*
 - A. a. Reserve medical officers now pursuing a full-time postgraduate course of instruction in medicine, at a college, university, or similar institution of higher learning, until completion of the current academic year of such training.
b. Reserve medical officers whose activity in teaching, research, and allied endeavors is considered by the appropriate Army Commander to be essential to the national health, safety, or interest.
c. Reserve medical officers residing in communities, the health of which, in the opinion of the appropriate Army Commander, would be unduly jeopardized if such officers were to be ordered to extended active duty.
9. Q. *How, when, and to whom should requests for delay be submitted?*

A. Requests for delay in call to active duty should be submitted in writing upon initial receipt of notification that call to active duty is contemplated. For members of the Reserve, such requests should be submitted to the headquarters responsible for the issuance of the notification, as authority has been granted by the Department of the Army to such headquarters to take appropriate action. Redlegation of this authority may be made by those commanders to subordinate headquarters commanded by a general officer or to a Chief of Military District. Only those requests that cannot be determined at Army Commander level will be forwarded to the Department of the Army (The Adjutant General, Attn: AGAO-C) for final appeal. In the case of National Guard personnel, requests for delay should be forwarded to the State Adjutant General.

10. Q. *Will medical units be brought to duty for training periods with their full complement of physicians and nurses?*

A. In order to assure that physicians and nurses are effectively utilized within the Department of the Army, only certain types of organizations will be brought to active duty with their full complement of such personnel. These types are as follows:

- Infantry Division
- Armored Division
- Airborne Division
- Hq and Hq Det, Med Bn, Sep
- Hq and Hq Det, Med Gp
- Medical Clearing Company, Sep
- Medical Field Laboratory, Army
- Field Hospital
- Mobile Army Surgical Hospital
- all non-medical units with medical personnel included in its T/O

Other types of medical units, such as those reflected below, will not be brought to active duty with their full complements of physicians and nurses, but with the number considered necessary for effective training. Additional personnel will be ordered to active duty at such time as the unit is to become operational:

- Evacuation Hospital, semi-mobile
- Evacuation Hospital (750 patient)
- Convalescent Center, Army
- General Hospital, 1000 bed
- Station Hospital, 500 bed
- Station Hospital, 300 bed
- Station Hospital, 200 bed
- Station Hospital, 100 bed
- General Laboratory
- Hospital Train
- General Dispensary (MB)

11. Q. *Are members of the inactive and honorary reserve eligible for call?*

A. Officers in the Inactive Reserve are subject to call to active duty on the same basis as officers in the Active Reserve. Officers in the Honor-

ary Reserve may be called to active duty only with their consent.

12. Q. *Is there an immediate need for senior medical officers?*

A. No, except for certain specialties, such as:

<i>Military Occupational Specialty Number</i>	<i>Specialty</i>
3000 or 3500	Staff or command
3005	Preventive medicine
3101	Tuberculosis
3129 and/or 3130	Psychiatry
3139	Internal medicine
3150	General surgery
3303 and/or 3325	Medical laboratory or pathology

13. Q. *Will reserve officers with long periods of active military service be given consideration in call to active duty?*

A. Present policies of the Department of the Army require that individual selection of officers of the Medical Corps Reserve for active duty be made, whenever feasible, from among those with no previous active military service, followed by officers with less than one year of extended active duty, and so forth. In the case of individuals who are members of units ordered to active duty, if the individual officer feels that his circumstances justify a delay in call to active duty, necessary request in writing should be submitted through his commanding officer to the Headquarters authorized to take action on such requests.

14. Q. *Is any effort being made to obtain the services of former ASTP participants and those who did not serve during the last war?*

A. Legislation has been introduced in the present session of Congress, which, if enacted into law, will require military service of those persons, among others, who received a portion or all of their medical education under the Army Specialized Training Program or the Navy V-12 Program and who have not served in the Armed Forces subsequent to completion of their medical education. It is important, however, to realize that the successful implementation of any legislation of this nature will require a lapse of some months. As an example, nation-wide registration of persons of any category embraced in any legislation, under such conditions as might be prescribed therein, will, in itself, be a necessary but time-consuming preliminary.

15. Q. *How have quotas for recalls been allocated to Army Areas?*

A. Quotas for recall to active duty of individual Reserve Medical Corps officers have been allocated by grade and military occupational specialty on the basis of number of physicians to population in each Army Area.

16. Q. *In what grade will reserve officers be recalled?*

A. Reserve officers, irrespective of whether called to active duty voluntarily or involuntarily, will

be called in the grade in which they are currently commissioned in the Officers' Reserve Corps.

17. Q. *Who is entitled to additional professional pay?*

- A. It is the opinion of the Surgeon General, Department of the Army, that, prior to the issuance of orders calling him to active duty, any medical or dental officer of the ORC or National Guard who volunteers for, and is accepted for, extended active duty for a period of at least 21 months is entitled to be classified as a volunteer under the provisions of Section 203 of the Career Compensation Act of 1949 and to receive additional special pay of \$100 per month. This opinion is subject to the confirmation of the Comptroller General.

EXCERPTS FROM MINUTES OF BOARD OF TRUSTEES MEETINGS

July 27, 1950

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Thursday, July 27, 1950, in the Governor's Room, Penn-Harris Hotel, Harrisburg, Pa.

Members in attendance were: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagion (12th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Malcolm W. Miller, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Allen W. Cowley (Public Relations), Dudley P. Walker (Medical Economics), and John O. Bower (Acute Appendicitis Mortality), Howard K. Petry, and Messrs. Lester H. Perry, executive secretary, A. H. Stewart, Jr., managing editor and convention manager, Leo E. Brown, executive assistant of Committee on Public Relations, and Robert L. Richards, Harrisburg office staff secretary.

THIRD ANNUAL STATE DINNER

Dr. George F. Lull, secretary and general manager of the American Medical Association, will be the principal speaker at the State Dinner on Monday, October 16. Dr. Lull, who was so popular at the 1950 Secretaries and Editors Conference, returns again to enlighten us on the current problems facing the profession. There will also be outstanding entertainment. Get your tickets now by using the form on page 1008.

The minutes of the meetings of March 11-12 were approved as circulated.

Reports of Board Committees

Finance Committee: Chairman Whitehill referred to reports, expenditures, and balances as found in the June 30 financial statement of the secretary-treasurer.

It was moved (Dr. Lorenzo), seconded (Dr. Banks), and unanimously carried that the report of the Finance Committee be accepted with approval of the recommended contribution of \$100 to the World Medical Association.

Building Committee: Dr. Francis J. Conahan presented the report of the Building Committee, which the chairman declared received.

Library Committee: Dr. Frank A. Lorenzo presented the report of the Library Committee.

It was moved (Dr. Gagion) and seconded (Dr. Banks) that the report of the Library Committee be accepted as circulated (see p.r.).

Reports on Medical Defense Cases

Second Councilor District—case No. 374 postponed.

Eleventh Councilor District—case No. 380 pending.

Twelfth Councilor District—case No. 368 pending.

Reports of Officers

President Samuel reported that he and others representing the Society would meet in Washington, D. C., July 29, with the American Medical Association Council on Civilian Defense.

Dr. Samuel gave a full report of the Conference of State Medical Society Presidents in San Francisco.

He called attention to the proposed amendment to the By-laws governing the change in the method of selecting the committee to annually nominate delegates to the American Medical Association (see call to 1950 meeting in June and September PENNSYLVANIA MEDICAL JOURNAL).

Secretary-treasurer Donaldson, in his report, stated that the American Medical Association would rebate to state societies 1 per cent of AMA 1950 dues collected, amounting to approximately \$2,400 for our society which should be equitably divided with our component societies. He recommended that 15 cents of each 25 cents rebated be returned to the county society and 10 cents be retained by the State Society.

It was moved (Dr. Gagion) and seconded (Dr. Whitehill) that the recommendation on the American Medical Association rebate in the secretary-treasurer's report be approved.

Dr. Donaldson, continuing with that portion of his report entitled "Veterans Loan Fund MSSP," recommended that the total amount in the fund, including the 10 per cent reserve, be promptly returned in proper proportion to certain county societies for ultimate distribution.

It was moved (Dr. Whitehill) and seconded (Dr. Lorenzo) that the Veterans Loan Fund account be closed in the manner indicated in the secretary-treasurer's report. The motion was carried.

Chairman Klump requested Dr. Whitehill to present his point of view in connection with that portion of the

secretary-treasurer's report to the House of Delegates entitled "War and Defense Emergency." (See August PMJ.)

Dr. Whitehill proposed (1) that we appoint a committee at once to develop the order in which Pennsylvania physicians may be chosen by Procurement and Assignment Service; (2) that this Procurement and Assignment Committee be planned similarly to that which the Society had in World War II; and (3) that the Board committee meet promptly to work out these problems.

(SECRETARY-TREASURER'S NOTE: This board committee met in Harrisburg on Aug. 13, 1950, named the Procurement and Assignment Committee for Pennsylvania subject to approval by the Board, prepared principles for the guidance of the Procurement and Assignment Committee, and requested a special meeting of the Board of Trustees for August 27 to confirm their actions and to discuss other necessary phases of civilian defense and procurement and assignment of medical manpower in the Keystone State.)

It was moved (Dr. Gagon) and seconded (Dr. Sweeney) that the chairman appoint a committee consisting of Drs. Samuel, Whitehill, Appel, and Gardner to formulate plans and nominate candidates for a committee for the immediate procurement and assignment of the wartime services of the medical profession of Pennsylvania. The motion was carried.

PRESIDENT-ELECT GARDNER: We should have some instructions from this Board as to getting into military service the V-12 and the ASTP trainees.

DR. ALTEMUS: This board can recommend only that these younger groups enter military service promptly. The Society cannot compel them to volunteer.

Mr. Perry, in connection with his report, read a letter from the Pennsylvania Society for Crippled Children and Adults, Inc.

It was moved (Dr. Gagon), seconded (Dr. Altemus), and carried that the president of the Society be requested to invite the members listed in this letter of July 19 from the Crippled Children's Society to serve on the medical advisory committee of the Society for Crippled Children and Adults.

It was moved (Dr. Altemus) and seconded (Dr. Gardner) that Dr. Thomas J. Cush also be invited to serve on the Committee for Crippled Children. The motion was carried.

Mr. Perry read a report from the AMA Commission on Chronic Illness.

It was recommended that the first objective should be to make a survey of existing places in Pennsylvania to carry on such a program, and that the survey be assigned to the Commission on Physical Medicine and Rehabilitation, at least in the interim before the annual convention.

Report of Convention Manager

This report, which had been previously distributed to the members of the Board, was accepted (see permanent record).

Mr. Stewart reported approximately 100 technical exhibits and 40 scientific exhibits scheduled for the

1950 convention in Philadelphia. He also announced the program for the Religious Hour on Sunday, October 15.

Report of Commission on Acute Appendicitis Mortality

Chairman John O. Bower presented his report on the hospital survey which had been conducted. Copies of this report were previously distributed to the members of the Board of Trustees.

It was moved (Dr. Altemus), seconded (Dr. Banks), and carried that this report be accepted with the proviso that the legislative suggestion be referred to the Committee on Public Health Legislation.

Report of Committee on Public Health Legislation

This report had previously been distributed to the members of the Board of Trustees. It was received with thanks.

Dr. Whitehill stated that a committee of the Legislature, with the cooperation of the state insurance commissioner, will study the recodification of Pennsylvania laws governing insurance.

It was moved (Dr. Whitehill) and seconded that Secretary Donaldson write a letter to Mr. Artemus Leslie, the insurance commissioner, requesting that Dr. Palmer be appointed to the committee to revise health and accident insurance laws. The motion was carried.

Report of Committee on Public Relations

Chairman Cowley presented the committee's report as previously distributed (see permanent record), laying great stress on the topic "Complementing AMA Radio Campaign in Pennsylvania"; the objective is to be assured that all of the radio stations in Pennsylvania that have cooperated satisfactorily with our public relations activities shall be included in the paid radio advertising campaign contemplated nation-wide by the American Medical Association, or, if this is not feasible, to be included by means of a supplementing fund provided by our state society. It was estimated that the total additional expenses to meet this situation in Pennsylvania would range between \$3,000 and \$6,000.

This proposal was freely discussed.

It was moved (Dr. Gagon), seconded, and carried that Chairman Klump should confer by telephone with proper representatives of the American Medical Association regarding the proposal for distribution of radio advertising funds in Pennsylvania.

(SECRETARY'S NOTE: See report on this telephone conference as it appears in the minutes of the July 28 meeting of the Board.)

Report of Benjamin Rush Award Committee

Chairman Appel reported that his committee has decided on the Trexler Foundation of Lehigh County, and as the individual to receive the 1950 award—Leroy Mikels of Monroe County.

It was moved (Dr. Conahan), seconded, and carried that this report be accepted.

On motion duly seconded and carried, the meeting adjourned at 11:45 p.m. to be reconvened Friday morning at 9:15 a.m.

GEORGE S. KLUMP, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

July 28, 1950

The Board of Trustees reconvened Friday, July 28, 1950, in the American Room, Penn-Harris Hotel, Harrisburg, at 9:15 a.m.

Members in attendance were: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Robert P. Banks (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), Thomas R. Gagion (12th).

Officers present were: Drs. E. Roger Samuel, president; Walter F. Donaldson, secretary-treasurer; Harold B. Gardner, president-elect; Louis W. Jones, first vice-president; and Malcolm W. Miller, assistant secretary-treasurer.

Committee chairmen and others present were: Drs. C. L. Palmer (Public Health Legislation), Charles Wm. Smith (Commission on Graduate Education), Robert P. Dutlinger (medical coordinator to the Committee on Civilian Defense), Howard K. Petry, and Messrs. Lester H. Perry, executive secretary, A. H. Stewart, Jr., managing editor and convention manager, Leo E. Brown, executive assistant to the Committee on Public Relations, and Robert L. Richards, Harrisburg office staff secretary.

Chairman Klump called the meeting to order.

CHAIRMAN KLUMP: The special committee of the Board of Trustees to nominate a committee for the procurement and assignment of medical officers from Pennsylvania and to prepare principles for its guidance has a progress report to make.

DR. WHITEHILL: I think we suggested that President Samuel be our committee chairman.

We wish to report to the Board at the present time the following general principles:

1. There shall be a state-wide committee of five on procurement and assignment whose duty it shall be to plan for cooperation by each component county medical society.

2. This committee shall consist of members ineligible for military medical service, but at least two on the committee must have had previous military experience.

3. Each member of the board committee shall present five names from which shall be selected the state Procurement and Assignment Committee of five with acceptances obtained by August 15.

4. The board committee shall request a special meeting of the Board of Trustees when prepared with the nominations and an administrative plan.

DR. DONALDSON: I think you should stipulate that one of the two committee men with military service should have had overseas service.

DR. KLUMP: The matter of cooperation and correlation with the effort of our existing Committee on Military Affairs should also be taken into consideration.

The chairman recommended that this report be accepted.

President-elect Gardner requested that each trustee and councilor submit names to him for consideration as appointees to commissions and committees.

Unfinished Business

Report of Trustees on Recommended Type of Security for Reinvestment

Dr. Gagion reported that from all information that he has received government bonds are considered to be the safest investment.

Dr. Conahan received a similar opinion from bankers.

Chairman Whitehill, for the Finance Committee, advised the purchase of \$10,000 worth of U. S. Savings "G" Bonds for the Medical Benevolence Fund, and \$20,000 of U. S. Savings "G" Bonds for the Educational Fund, same to be paid for with monies in the Society's savings accounts Nos. 110596 and 3312, respectively, and the bonds to be placed in safekeeping with other bonds of the Society in the Peoples First National Bank and Trust Company.

It was moved (Dr. Gagion), seconded (Dr. Hogan), and carried that Secretary-Treasurer Donaldson be authorized to purchase \$30,000 worth of U. S. Savings Bonds Series "G" for these funds—\$10,000 for the Medical Benevolence Fund and \$20,000 for the Educational Fund.

Liaison with Pennsylvania State Dental Society

DR. KLUMP: The Dental Society requested a meeting with a committee and that meeting is arranged for this afternoon. Drs. Cowley, Palmer, Walker, and myself will meet with them at 2:30 p.m. today.

New Business

Dr. Donaldson read a communication from Dr. Russell S. Anderson, the State Medical Society representative of the Pennsylvania Tuberculosis and Health Society (see Appendix A).

It was moved (Dr. Appel) and seconded (Dr. Gagion) that Dr. Anderson be continued as representative. The motion was carried.

Dr. Donaldson then reported the receipt from the Pennsylvania Tuberculosis and Health Society of a bill for \$450 for 15,000 copies of the Pennsylvania Public Health Survey Digest which has been referred to in the past as the "digest of the digest," copy of which has been distributed to members of the Board. Its cover page bears the title "Pennsylvania's Health Is Your Concern!" These were ordered with the understanding that a copy would be distributed to each member of the State Society, the balance to be distributed elsewhere (indefinite).

DR. KLUMP: I feel that I can speak for the Commission on Preventive Medicine and Public Health when I say that they hope the Board will authorize distribution of this with a covering letter signed by the president. Those who made the survey represent the outstanding public health organization on the national level.

DR. GAGION: I would like to have time to peruse the pamphlet before authorizing it to be sent.

DR. DONALDSON: The additional 300 copies of the "Keystones of Public Health for Pennsylvania" which were ordered in the name of the State Medical Society have not been delivered, but will be when paid for (paid August 1).

Report of Delegate to U. S. Pharmacopeial Convention

DR. DONALDSON: Dr. Hugh McCauley Miller supplied a report based on his attendance at this convention, which will be published in the *PENNSYLVANIA MEDICAL JOURNAL*, probably in October.

Report of Pennsylvania Division of American Cancer Society

DR. DONALDSON: This is an informatory report which was previously distributed and is self-explanatory (see permanent record).

DR. ALTEMUS: Dr. George W. Ramsey, of Washington, wrote to me asking to be relieved as a director of the American Cancer Society. In his place I would recommend Dr. Gerald C. Leary, pathologist of Johnstown.

Election of Associate Members

Secretary Donaldson presented a list of the associate members submitted by county medical societies for election (see Appendix C).

It was moved (Dr. Gagon), seconded (Dr. Altemus), and carried that these men be elected as associate members.

DR. APPEL: This board referred certain communications to the delegates to the American Medical Association to act upon:

1. A resolution from the McKean County Medical Society advocating the return to county medical societies of a percentage of the AMA's annual dues devoted to public relations. We decided in caucus to not introduce this subject to the House of Delegates inasmuch as the Education Campaign includes advertising in local papers and over local radio stations.

2. A resolution from the Pennsylvania Radiological Society endorsing the original Hess report and urging its strict enforcement. Because of the history of this report in the 1949 interim session and of its reception in the 1950 AMA House of Delegates, your delegates voted to table this resolution.

(SECRETARY'S NOTE: The amended report of the AMA Committee on Hospitals and the Practice of Medicine appeared on page 1090 of the July 22, 1950 issue of the *Journal AMA*. This report should be clipped and filed by the management of every approved hospital in Pennsylvania, as well as by organizations of radiologists, anesthesiologists, and pathologists, and by the proper officers of each component county medical society including the Committee on Hospitals and Professional Relations, which "should be available to receive complaints from any physician, hospital, medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals.")

3. The Board of Trustees referred to your delegates a communication from the New Jersey State Medical Society requesting our study and possible co-sponsorship of an attached proposal of the Medical Society of New Jersey for a National Health and Medical Care Program. Your delegates voted not to co-sponsor or endorse this New Jersey plan.

DR. KLUMP: There were a number of similar resolutions by state society delegations.

Dr. Donaldson called attention to a communication from Secretary Lull of the American Medical Association regarding a complaint lodged with him from a Pennsylvania physician who was refused admittance to the medical society of his county after approval by its board of censors and again refused by the county society after an appeal board composed of the district censors of the councilor district under the chairmanship of the trustee and councilor unanimously recommended his acceptance as a member. This dissatisfied physician, writing to Dr. Lull, asks if he has further source of appeal and makes veiled threats of a legal suit.

After a long and free discussion in which the fact was stressed that our by-laws make no provision for appeal beyond that already taken, no action was taken on the complaint.

Correspondence

Dr. Donaldson read two resolutions from the Pennsylvania State Society of Anesthesiologists (see permanent record) which dealt with their claims for support in having the Medical Service Association of Pennsylvania establish a schedule of benefits for anesthesia, diagnostic and therapeutic blocks administered by doctors of medicine other than operating surgeons to be included in all subscriber certificates issued by the Medical Service Association of Pennsylvania.

Dr. Appel, in opening the discussion, stated that he also had resolutions from various sources on the same subject. He stated that he was a member of a committee of the Board of Directors of the Medical Service Association of Pennsylvania appointed to investigate this particular problem which is of concern to not only anesthesiologists but radiologists, physiotherapists, and pathologists.

After an informative and exhaustive study, meticulously reported, Dr. Appel came to the following conclusion: If the Medical Service Association were to assume as part of its subscription agreement the various medical specialties, it would also be necessary to increase the subscription rates to cover additional administrative expenses which would be incurred; therefore, we couldn't do this without a very substantial increase in our subscription rate.

The subject was further discussed by Drs. Sweeney and Samuel.

It was moved (Dr. Whitehill) and seconded (Dr. Altemus) that the resolutions from the Pennsylvania Society of Anesthesiologists be referred to the board of directors of the Medical Service Association of Pennsylvania. The motion was carried.

Dr. Donaldson read a resolution received May 31 from the National Association of Boards of Pharmacy seeking our influence in the House of Delegates of the American Medical Association in favor of rigid observance of the AMA Code of Ethics as it affects group and clinic practice combined with ownership of a pharmacy.

At this point in the order of business a recording of the telephone conversation between Chairman Klump, a representative of Whitaker & Baxter in Chicago, and AMA Secretary Lull in Washington, D. C., regarding the allotment and disposition of AMA educational campaign funds in Pennsylvania, was transmitted in the hearing of the Board members.

At its conclusion Chairman Klump quoted Dr. Lull as saying, "There is plenty of time to take another look and I will take the subject up with Whitaker & Baxter next week." Dr. Lull implied that the current international war situation might develop to a point where the AMA may change its plans. He said the omission of foreign language newspapers from the proposed advertising list was due to their great numbers, and the same is true of trade publications.

(**SECRETARY'S NOTE:** A transcript of the telephone conversation between Chairman Klump and Mr. McLaughlin of Whitaker & Baxter in Chicago was distributed to the members of the Board of Trustees and others on August 11.)

After considerable discussion it was suggested that the subject might be further discussed at a proposed special meeting of this Board of Trustees in connection with the study of civilian defense and procurement and assignment which is likely to be held early in September.

Chairman Klump mentioned two alternatives open to Whitaker & Baxter: (1) provide full advertising and broadcasting coverage in Pennsylvania, or (2) permit our society to spend the money allotted. Dr. Klump further stated that they do not consider the problem urgent and wish to postpone decision until they have more knowledge of the ultimate outcome of the war in Korea.

Dr. Gagon considered these two items pertinent. Dr. Whitehill stated that the Committee on Public Relations should proceed with its plans to cover the approved broadcasting stations in Pennsylvania which are not covered by AMA, the cost to be adjusted in the committee's 1950-51 budget.

Dr. Whitehill made a motion to this effect which was seconded by Dr. Altemus and the motion was carried.

Dr. Sweeney, at this point, announced that he would recommend Dr. Walter E. Egbert as a member of the board of directors of the Medical Service Association of Pennsylvania to replace Dr. Kenneth Scott, of Chester County, who resigned.

Report of Commission on Graduate Education

(Previously distributed—see permanent record)

It was moved (Dr. Whitehill) that the informatory report of the Commission on Graduate Education be received. The motion was duly seconded and carried.

Report of Commission on Emergency Disaster Medical Service

Dr. Charles Wm. Smith stated that after a conference with Chairman Theodore R. Fetter he was reporting for the commission; he explained further that there had been no time to have the report transcribed, so it was presented orally. (**SECRETARY-TREASURER'S NOTE:** Dr. Smith's mimeographed report was distributed August 17.)

It was moved (Dr. Sweeney), seconded (Dr. Whitehill), and carried that Dr. Smith's report be accepted as given.

The board meeting was formally adjourned at 1 p.m.

GEORGE S. KLUMP, *Chairman,*

WALTER F. DONALDSON, *Secretary-Treasurer.*

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Lackawanna County ...	\$5.00
Woman's Auxiliary, Schuylkill County	130.00
Woman's Auxiliary, Armstrong County	60.00
Woman's Auxiliary, Westmoreland County	
A friend, in memory of Mrs. Miriam McMurray	10.00
Previously reported	10,168.77

Total contributions since 1949 report ...\$10,373.77

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since June 30. Figures in first column denote county society numbers; second column, State Society numbers.

July 1	Westmoreland	206-207	10161-10162	\$46.00
	Luzerne	367-368	10163-10164	46.00
	Berks	248	10165	23.00
5	Schuylkill	161	10166	23.00
10	Montgomery	348	10167	23.00
	Armstrong	43	10168	23.00
11	Luzerne	369-370	10169-10170	46.00
	Northampton	236	10171	11.50
	Allegheny	1573-1583	10172-10182	253.00
	Warren	50	10183	11.50
17	Montour	40	10184	23.00
	Berks	249	10185	23.00
	Monroe	40	10186	23.00
19	Philadelphia	2955-3042	10187-10274	2,024.00
24	Lycoming	142-143	10275-10276	34.50

CHANGES IN MEMBERSHIP

New (23) and Reinstated (10) Members

ALLEGHENY COUNTY: John B. Moyer, George Miller Shadle, William D. Stewart, and Edward Alton Tyler, Pittsburgh.

ARMSTRONG COUNTY: (Reinstated) Donald H. Schumaker, Leechburg.

BERKS COUNTY: George L. Rubright, Reading. (R) George S. Pettis, Reading.

CHESTER COUNTY: John B. Thomas, West Chester.

GREENE COUNTY: (R) William S. Gibson, Mt. Lebanon.

LUZERNE COUNTY: (R) Francis A. Blaum, Wilkes-Barre.

LYCOMING COUNTY: George J. Callenberger, Hughesville.

MONROE COUNTY: Ruth R. Knobloch, Blakeslee.

MONTGOMERY COUNTY: (R) Samuel Hankin, Abington.

MONTGOMERY COUNTY: Willard Hayes Love, Jr., Danville.

NORTHAMPTON COUNTY: William A. Cull, Easton.

PHILADELPHIA COUNTY: Frank W. Blair, Bernard M. Blum, Robert McClelland Day, Alfred S. Frantz, John A. Fust, Herbert S. Greenspan, Jack Henry Kamholz, Peter Knowlton, W. Bosley Manges, Moses Rabson, Richard M. Silberstein, and Susan Wight, Philadelphia. (R) Walton S. Burris, Newtown; James H. Cunningham, Philadelphia; Roycroft C. Jones, Butler; Sterling A. Mackinnon, Norristown; Alfred R. Seraphin, Philadelphia.

WARREN COUNTY: Lee James Borger, Warren.

Resignations (2), Transfers (3), Deaths (4)

ALLEGHENY: *Transfer*—Julius W. Ambrose, Pittsburgh, from York County Society. *Death*—Samuel J. S. Fife, Bridgeville (Univ. of Pgh. '93), July 18, aged 81.

CAMBRIA: *Resignation*—John J. Silensky, W. Va. *Death*—Harry H. Miller, Johnstown (Eclectic Med. Coll. '02), July 3, aged 78.

ERIE: *Transfer*—Douglas B. Nagle, Erie, from Philadelphia County Society.

LYCOMING: *Deaths*—James D. Beach, Williamsport (Jeff. Med. Coll. '95), July 3, aged 80; Frederick C. Lechner, Montoursville (Jeff. Med. Coll. '19), July 21, aged 60.

NORTHAMPTON: *Transfer*—John A. Hampsey, Easton, from Allegheny County Society.

PHILADELPHIA: *Resignation*—William L. Drake, Jr., Indianapolis, Ind.

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The following requests were filled during the month of July:

Collagen diseases	Herpes zoster
Peyronie's disease	Sound
Amniotic fluid embolism	Hearing aids
Vasomotor system	Noise
Multiple sclerosis	Psychology of hearing
Rh factor	Vitamins in arthritis
Tumors of the testicles	Peripheral neuropathies
Treatment of scabies	New test for cancer
Lead poisoning	Neurofibrosarcoma
Air embolism	Pituitary disorders
Emotional maturity	Plastic surgery
Urolithiasis	Spider bites
Cholesterol metabolism	Bee stings
Atomic energy	Neuroblastoma
Toxicity of stilbestrol	Pulmonary disease
Progress in medicine	
Subacute bacterial endocarditis	
Hydatidiform mole and chorio-epithelioma	
Lithium salts and the effects on the body	
Neurofibromatosis in children	
Physiology of intravenous procaine	
Benign lesions of stomach	
Potassium deficiency in diabetes and infant diarrhea	
Tuberculosis of the pelvis	
Licensed mental hospitals in Pennsylvania	
Prevention and control of diabetes mellitus	
Stilbamidine therapy in multiple myeloma	
Anesthesia for outpatients	
Medical groups in California	
Blood transfusion in infancy and childhood	
Congenital dislocation of the hip in infants	
Granulomatous diseases of the colon	
Psychology in general practice	
Recklinghausen's disease	
Arteriographic examination	
Mortality of insect bites	
Mortality rate of poliomyelitis	
Cancer mortality rates in Pennsylvania	
Recent advances in therapeutics	
Qualifications for a medical social worker	

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

AN ADEQUATE diet is universally accepted as one of the protective measures against infection by the tubercle bacillus and as an essential factor in treatment. In infections caused by other organisms, however, the relationship between resistance and good food is not clear-cut and much careful research remains to be done.

NUTRITION AND INFECTION

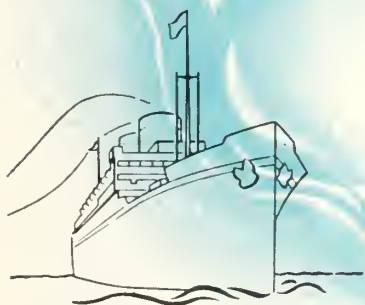
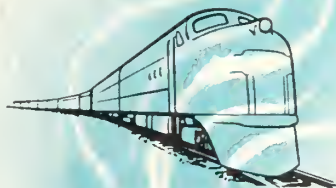
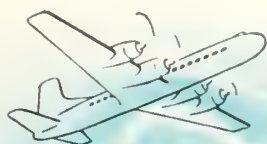
Every mother of a family, and every doctor in practice, firmly believes that the best bulwark against infection is good wholesome food. The association of tuberculosis with poverty and malnutrition is particularly noteworthy. In the late war the countries with the highest incidence of tuberculosis were those that suffered the greatest privations and food shortages. But, other factors besides nutrition may well have been involved. The poorly fed community often suffers from fatigue, low morale, anxiety, overcrowding, and poor hygiene, and its hospital and public health organizations are likely to be defective. Moreover, in spite of the appallingly low nutritional standards in Germany at the end of the war, there were no major epidemics. Then again, children brought up in apparently admirable living and dietary conditions still contract measles, chickenpox, mumps, and poliomyelitis, and well-fed adults catch colds and influenza. Poliomyelitis, indeed, seems to have a predilection for young adults in excellent physical condition; and the incidence appears to be much higher in well-fed countries like the United States than in, for example, the ill-nourished African. Most bacteriologists, therefore, hesitate to accept the view that malnutrition increases susceptibility to infection.

The influence of heredity, both in the host and in the infecting organism, cannot be overlooked. Webster, by inbreeding and selecting from a common stock of mice, bred two strains, one

of which was almost completely immune to a given infective dose of *Salmonella enteritidis*, and the other suffered almost a 100 per cent mortality. Such inbreeding and selection, however, did not produce resistance to other organisms.

If nutrition plays a part in the resistance to infection, one would expect antibody production to be affected, particularly as antibodies are derived from the serum proteins, which are lowered in frank malnutrition. At the end of the war Gell had an exceptional opportunity for studying the relation between protein deficiency and antibody response in patients and prisoners from the Ruhr suffering from malnutrition—they were on a diet of only 1000 calories daily. Their antibody response, as measured by agglutination tests, was determined before and after infection with a rather bizarre mixture of tobacco mosaic virus and avian red cells, chosen because there could not be preformed latent immunity to them. British troops served as controls. The results showed that the well-nourished British soldier had a better antibody response than the half-starved German, but the differences, though statistically significant, were not as great as might be anticipated. Gell concluded that "undernutrition does not play as large a part in widespread epidemics as is generally supposed."

Vitamin C was once thought to be associated with immunity mechanisms in the body, but evidence is not very convincing. Early work indi-



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1. Council on Pharmacy & Chemistry: New and Non-official Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

*Trademark of G. D. Searle & Co., Chicago 80, Ill.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

cating a direct correlation between blood vitamin C levels and complement formation has not been confirmed. On the other hand, a controlled experiment of Glazerbrook and Scott Thomson, in 1938, seemed to show a definite increase in the resistance of schoolboys against tonsillitis, pneumonia, and acute rheumatism—but not colds—when they were given full doses of vitamin C. There is evidence that vitamin C is bacteriostatic, but only in concentrations that could never be reached in the body. Large quantities of vitamin C are often given to patients with infections because their excretion of the vitamin is diminished, but whether the vitamin C level in the tissues and blood of the normal person affects his susceptibility to infection or the virulence of the attack is not proved. Vitamin A has been named the “anti-infective vitamin” without very firm evidence.

Much work has been done in the past decade on the effect of nutrition in experimental infections in animals, but most of it presents such confusing and, at times, conflicting results that it is difficult to draw any general conclusions. Experimental work on viruses, however, has established that the virus and the cells of its host compete for nutrients that are essential for vital enzyme mechanisms in both. If the virus prevents the host cells from utilizing these essential

nutrients, and appropriates them for its own purposes, then the host cells will suffer and may eventually die. Conversely, if the virus is starved of some of its essential nutrients, it cannot live. Viruses thrive best in tissues whose metabolism is active—as in the developing hen's egg—and the typical picture of several virus diseases in animals can be markedly altered by a variety of dietary deficiencies. Animals on diets deficient in members of the vitamin B complex often show a heightened resistance to some viruses, such as that of poliomyelitis, so that if they do become infected the disease runs a mild course. This and the low incidence of poliomyelitis among poorly nourished people may be examples of “starving out the virus.” With bacterial and protozoal infections a deficiency in vitamin B complex generally increases susceptibility to infection. Lack of some members of the B complex produces leukopenia, which interferes with phagocytosis. Interesting as these experimental observations are, we must not assume that they have an immediate application to human problems. Nevertheless, Howie suggests that experiments on mice “offer the best hope of giving shape to the present vague mass of information.”

Editorial, The Lancet—London: Saturday, December 24, 1949.

FEEDING THE TUBERCULOSIS PATIENT

An ordinary, but well-prepared and varied diet, consisting of meat, fish, milk products, eggs, citrus fruits, green vegetables, and whole grain cereals, served with definite regularity, has been found to be the best diet for tuberculosis patients.

The quantity of food should be increased about 30 per cent above that required by a normal individual of the same physique, to provide for the increased metabolism of these patients, and to maintain their weight at about normal levels. Obesity is not desirable.

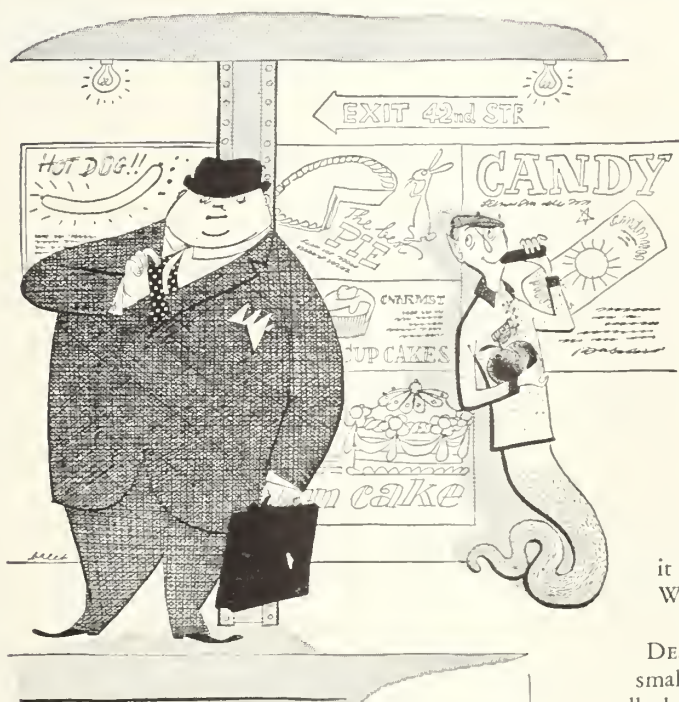
The protein allowance is reasonably high, 100 to 150 grams daily, in order to provide the body with sufficient material to repair the damaged tuberculous tissues. Animal proteins are considered more valuable than vegetable. Excesses of protein and carbohydrate are inadvisable as they may increase pulmonary ventilation and counteract somewhat the benefits of bed rest. Fats are usually well tolerated by tuberculosis

patients and are conveniently supplied in dairy products, fish, and marbled meats. Carbohydrates should consist of fruits, vegetables, cereals, and simple desserts. The optimal amount of vitamins, including A and C, is well provided for in this diet. Vitamin D, however, must usually be added as cod liver oil or concentrate. As far as possible, patients should be given their calories in the kind of food they are accustomed to and like. Between meals, feedings are best omitted. Patients should be taught that although milk is beneficial, a varied diet is even more so.

Proper dietary management is only one facet of intelligent and sympathetic patient management. In tuberculosis, the interdependence of doctor, nurse, dietitian, social and rehabilitation worker is especially marked.

Feeding the Tuberculosis Patient, Samuel Phillips, M.D., N.T.A Bull., January, 1950.

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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street, Indiana

MARY STEEL HAMMAN



Mary Steel Hamman, our president-elect and wife of Howard Harrison Hamman, Greensburg doctor of medicine, will be installed as the twenty-seventh president of the Woman's Auxiliary to The Medical Society of

the State of Pennsylvania, at the annual convention in October in Philadelphia.

Dr. and Mrs. Hamman and their two daughters—Eleanor, a teacher of English at Linden Hall, Lititz, Pa., and Betty, a junior at Allegheny College, Meadville, Pa. — reside in Greensburg, the present county seat of Westmoreland County, and have a summer home at Lake Udell.

Mrs. Hamman was born in historic Hannastown, the first county seat of Westmoreland County, where the Hannastown Resolutions of Independence were drawn up and adopted on May 16, 1775, and the home of the famous Rattlesnake Flag, "Don't Tread on Me," now on exhibition in the State Museum in Harrisburg. She was educated in the Greensburg public schools, Hurst High School, Leech's Business College, and Greensburg Business School, after which she pursued an active career in the business world.

Mrs. Hamman is public-spirited and club-minded. Her interests are varied and include public health, music, religious worship, public welfare, good citizenship, and good government. She has been very active in community affairs. She is a director and archivist and a former assistant coordinator of the Westmoreland County Cancer Fund; secretary of the Westmoreland County Health Assembly; a director of the Pennsylvania Association for the Blind, Westmoreland County Branch; and vice-chairman of the Greensburg Republican Committee. She holds membership in the Phoebe Bayard Chap-

ter, Daughters of the American Revolution; William E. Gelston Chapter No. 435, Order of Eastern Star; Auxiliary to Kedron Commandery No. 18; choir of the Westmoreland Shrine No. 18; American Legion Auxiliary; and Greensburg Community Club. Her former offices include finance chairman of the Greensburg Women's Club; secretary and legislative chairman of the Westmoreland County Federation of Women's Clubs; vice-president of the Westmoreland County Evening Council of Republican Women; and co-chairman of the Greensburg American Red Cross Campaign.

Mrs. Hamman is a member of the Otterbein Evangelical United Brethren Church, Greensburg, having served for the past 11 years as president of the choir. She is a member of the Council of Administration, Ladies' Aid Society, and Communion Committee.

Our president-elect has been an active member of the Woman's Auxiliary to the Westmoreland County Medical Society for the past 24 years. She has served her county auxiliary as treasurer, secretary, president, and director respectively. As a member of the state executive board, she has been an executive assistant, councilor of the Tenth District, and now president-elect.

Dr. and Mrs. Hamman attended the American Medical Association convention in San Francisco this June. They joined the conducted tour of the Allegheny County Medical Society. In addition to traveling, Mrs. Hamman's hobbies include antiques, flowers, and their summer home on their private lake.

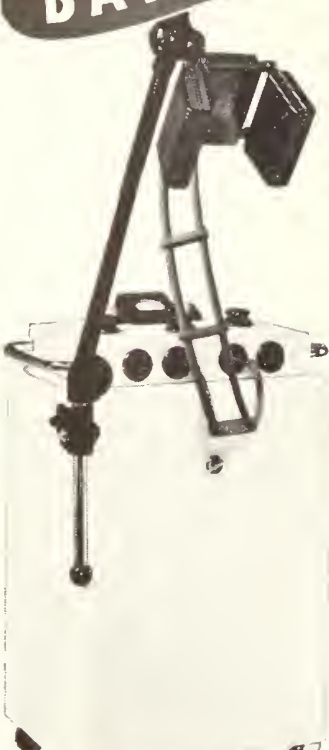
After a very busy year as president-elect, Mrs. Hamman will assume her new duties with a wealth of organizational experience and a keen interest in the welfare of all people. The Auxiliary can look forward to a successful year under her conscientious leadership.

(MRS. DANIEL H.) GLADYS OVERHOLT BEE.

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PRESIDENT'S MESSAGE



The Woman's Auxiliary to The Medical Society of the State of Pennsylvania will soon bring to a close its twenty-sixth year of service to the profession in which we are most interested. The end of the road will come at the annual meeting in Philadelphia.

At the beginning of this administration last September, I, as your president, compared your county auxiliaries to wheels, with their hubs, spokes, rims, and tires representative of the various officers and chairmen who would serve during the year. These wheels were to carry you along the road of coordinated programs and public relations, using maps and guideposts provided in the state and county by-laws and engineered by advisors and letters of instruction.

Reading your county reports has been an exciting experience. I cannot help but feel that I have been lifted to the top of a high mountain where, with binoculars in hand, I am privileged to watch the wheels come to the final stretch of the road, carrying the machines which have served you well this past year. From every direction they come loaded with treasures, the accomplishments of each county's efforts, the sum total of the work done by each individual member in the 62 organized auxiliaries.

The machines are of all types and vintages. Some are heavy and bulky, indicating an existence of 25 years, and heavily laden with gifts. Others are the latest models, their paint jobs shiny and with scarcely a scratch or dent to mark them as having been used at all. The wheels are large or small, depending upon the load that they must carry, but all travel in the same direction toward a common goal.

The drivers of these machines are capable and strong. Some, with years of experience in traveling the auxiliary highway, drive fast and with surety; others, new and timid, unaccustomed to their machines, follow carefully in the paths of the leaders up ahead. All wear a common uniform of loyalty and service to the auxiliary.

The gifts brought are too numerous to mention here in detail and must wait for the printed report of the year. But in expressing my thanks to all who have served in county and state auxiliary work, I would like to enumerate a few of

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There are good reasons why many allergists consider "late" hay fever a more serious threat than the Spring and Summer types of seasonal allergy: ragweed pollens cause a greater incidence of hay fever than all other pollens combined; more pollens are in the air during the ragweed season than at any other time; and since "the United States is the favorite habitat of ragweed, it has the dubious distinction of harboring more hay fever victims than all the rest of the world together."¹

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¹Cooke, R. A.: *Allergy in Theory and Practice*, Philadelphia: W. B. Saunders Company, 1947, p. 186



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the outstanding accomplishments which mark this year as one of progress and success.

Training my glasses upon these loaded machines, I see the following:

1. Over 500 new members added to our ranks. The total paid-up membership on March 1 was 4261, and many added since then will be reported to you at the state convention.

2. All counties now organized and actively participating in our program of outstanding public relations, except McKean County.

3. Hundreds of resolutions against compulsory health insurance, resulting from auxiliary contacts.

4. Thousands of personal contacts made by auxiliary members with their Congressmen and lay persons as a result of requests from the State Society.

5. Contributions to the Medical Benevolence Fund amounting to more than \$10,000. (Report incomplete at this date.)

6. Increased recognition of auxiliary worth by county societies and hope for more in the year to come.

7. Outstanding public relations between aux-

iliary members and all types of lay groups and individuals.

8. Hundreds of contributions in time, money, and effort to community projects all over the State. Whether large or small, they have created friendliness toward the profession.

9. Greater understanding of auxiliary functions by county members and increasing interest in programs designed to teach and educate, such as study groups and schools of instruction.

10. Recognition of the value of combining work with play all through the year's program.

I especially commend those who become more willing to take an active part in the work needed to be done and who devote some portion of their time to serving the Auxiliary.

I see more active participation by the general membership because of greater understanding of auxiliary aims and the reasons for existence. I am thrilled with the newer counties—their sense of responsibility and willingness to learn from "scratch." Their response to all requests and encouragement has been as refreshing as a cool breeze.

The revival of interest among older members who were trained to other ways in other days,

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GYNECOLOGY—Intensive Course, two weeks, starting September 25, October 23. Vaginal Approach to Pelvic Surgery, one week, starting September 8, November 6.

OBSTETRICS—Intensive Course, two weeks, starting September 11, November 6.

MEDICINE—Intensive General Course, two weeks, starting October 2. Gastro-enterology, two weeks, starting October 16. Gastroscopy, two weeks, starting September 11, October 23. Electrocardiography and Heart Disease, four weeks, starting October 2.

DERMATOLOGY—Formal Course, two weeks, starting October 16. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

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their tolerance toward youthful ambition and the labor of the newer ones coming along, has been wonderful to behold. It is not easy to *see* change take place too rapidly; it is much less easy to *participate* in that change in an active way. To those who have thus reacted we are grateful.

I see, too, that many are aware of the importance of appointing chairmen and electing officers who are willing to assume their duties with a feeling of responsibility, to study their jobs, and to see them through.

Best of all, I see that many of you report feeling that you would like to have done better, that something has been left undone. You report that plans are already made for improving your programs and enlarging your scope of activity in the next year. This, to my mind, is the best part of your reports, for it shows that you are interested in what happens *in* and *to* your county auxiliary. It provides your leaders of the coming year with an incentive to follow in your footsteps and gives them something to do in attempting to complete what you have started. In this I see progress and a future for our auxiliary.

It has been said that *belief* and *faith* combined can lead to miraculous accomplishment. In watching your approach toward the final road of

this year's journey in auxiliary experience, I cannot help but feel that you have *believed* in this auxiliary of ours and your *faith* in its worth has not been in vain. From my mountain top I am witnessing the miracle which you, in each county of the State of Pennsylvania, have wrought, and it is good to see.

The wheels have moved forward steadily all year and we approach the end of the journey confident that the treasures of accomplishment which you bring will surprise all of you as you see them gathered together for display.

In this, my last message to you through these pages, I wish to express my deep appreciation to all members of county and state auxiliaries who have contributed in any way to the year's success. I look forward to greeting all of you at the annual meeting in Philadelphia where we can share experiences, inspire next year's leaders, and speed them on their way down the Auxiliary Road.

(MRS. DRURY) ELIZABETH M. HINTON,
President.

TWENTY-SIXTH ANNUAL CONVENTION

YOU have a date to attend the twenty-sixth annual meeting of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania to be held in Philadelphia, October 15 to 19, 1950.

This year every effort has been made to plan for a happy combination of work and play so that your time will be well spent. The following program does not list all that is in store for you, for some of the plans are not yet completed, but it is hoped that those listed will whet your appetite.

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The Philadelphia committee under the leadership of Mrs. Hugh Robertson has the WELCOME mat all ready to spread before you at Auxiliary headquarters in the Bellevue-Stratford Hotel.

Further and full details of the entire program will reach every Auxiliary member about one month prior to convention time by way of The Keystone Formula, our new newsletter.

So—plan to come to Philadelphia in October.

YOU have a DATE with your state auxiliary.

PROGRAM

Twenty-sixth Annual Meeting of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania

October 15 to 19, 1950

Headquarters: Bellevue-Stratford Hotel, Broad and Locust Streets, Philadelphia.

Convention chairman—Mrs. Hugh Robertson, 310 Winding Way, Merion.

Co-chairman—Mrs. Hugh McCauley Miller, Wyncote.

Timekeeper—Mrs. Edgar S. Buyers, Norristown.

Sunday, October 15

4:00 p.m.

Religious Hour—Irvine Auditorium, University of Pennsylvania Campus. Speakers—Dr. Bertram W.

Korn, Senior Rabbi, Temple Keneseth Israel, Philadelphia; Dr. John S. Ladd Thomas, Dean, Temple University School of Theology, Philadelphia; and Dr. W. Hamilton Aulenback, Rector, Christ Church and St. Michael's (Episcopal), Germantown, Philadelphia. Music by the Men's Glee Club, University of Pennsylvania, Robert S. Godsall, director.

5:30 p.m.

Buffet Supper—Houston Hall, University of Pennsylvania campus.

Subscription—\$2.00

(Mail reservations for Buffet Supper, with check, to The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg. An order form will be found in this issue of the JOURNAL.)

Monday, October 16

(All Presidents' Day)

Registration—all day—Bellevue-Stratford Hotel.

8:00 a.m.

1949-1950 State Board breakfast (by invitation).

9:15 a.m.

Pre-convention Executive Board meeting.

Mrs. Drury Hinton, presiding.

(1949-50 county presidents and presidents-elect, and past presidents of the State Auxiliary are invited to attend this meeting.)

Official business.

12:15 p.m.

Luncheon—in honor of Mrs. Arthur A. Herold, president of the Woman's Auxiliary to the American

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Medical Association, Mrs. Drury Hinton, president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, and all county presidents who served with Mrs. Hinton during 1949-50. Mrs. J. Frederick Dreyer, presiding. Thanksgiving—Miss Mary Henry Stites. Introduction of 1949-50 county presidents—Mrs. Drury Hinton. Address—Mrs. Arthur A. Herold.

2:00 p.m.

Formal opening of twenty-sixth annual convention. General session.

Invocation—Mrs. Ralston O. Gettemy. Pledge of loyalty—Mrs. Harry W. Buzzard. Address of welcome—Henry B. Kobler, M.D., President, Philadelphia County Medical Society. Greetings—Mrs. Frank B. Lynch, President, Woman's Auxiliary to the Philadelphia County Medical Society.

Response—Mrs. Joseph E. Shelby. Business session.

4:15 to 5:30 p.m.

Tea honoring past state presidents, The Warwick, Seventeenth and Locust Streets. Mrs. Howard H. Hamman, presiding. Music by Mary DeProphetis, soprano.

7:00 p.m.

Third Annual State Dinner—Ballroom, Bellevue-Stratford Hotel. Nationally known speaker and excellent

floor show, including The Angelaires presenting Holiday for Harpstrings. Subscription—\$5.00.

(Mail reservations for the State Dinner, with check, to The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg. An order form will be found in this issue of the JOURNAL.)

Tuesday, October 17

9:00 a.m.

General session.

10:00 a.m.

"In Memoriam" service—Mrs. Harry B. Jones, presiding.

Soloist—Virginia Kendrick Clark.

Prayer—The Reverend Richard S. Bailey, Rector, Church of the Holy Comforter, Aronimink, Drexel Hill.

Report of Registration Committee.

Panel discussion: Medical Research.

Mr. Leo E. Brown, executive assistant to the Committee on Public Relations, moderator.

Participants: Mr. Ralph A. Rohweder, Executive Secretary, National Society for Medical Research, Chicago, Ill.

Dr. C. L. Palmer, Chairman, Committee on Public Health Legislation, The Medical Society of the State of Pennsylvania.

Dr. J. Parsons Schaeffer, Chairman, Committee on Defense of Medical Research, The Medical Society of the State of Pennsylvania.

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12: 15 p.m.

Luncheon in honor of the officers of The Medical Society of the State of Pennsylvania.

Mrs. Albert F. Doyle, presiding.

Thanksgiving—Mrs. William J. Jacoby.

Guest speaker—Mr. Leonard E. Read, President, The Foundation for Economic Education, Inc., New York City.

2: 30 p.m.

General session.

Election of delegates to 1951 national convention.

6: 30 p.m.

Dinner—Past State Presidents' Club (by invitation).

8: 15 p.m.

General meeting of The Medical Society of the State of Pennsylvania to be held in the ballroom of the Bellevue-Stratford Hotel.

Installation of Harold B. Gardner, M.D., as 101st president of The Medical Society of the State of Pennsylvania.

Presentation of certificates for continued attendance at the Graduate Education Institute. Wallace M. Yater, M.D., Washington, D. C., speaking on "Keeping Abreast of Medical Progress."



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1. Withering, W.: An account of the Foxglove, London, 1785.
2. Rimmerman, A. B.: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1945.

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Wednesday, October 18

9:00 a.m.

General session.
Unfinished business.
New business.
Report of the resolutions committee.
Report of the nominating committee—Mrs. Paul C. Craig.
Election of officers.
Installation of officers for 1950-51—Mrs. Paul C. Craig.
Presentation of gavel to Mrs. Howard H. Hamman by Mrs. Drury Hinton.
Address—Mrs. Howard H. Hamman, president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania.
Presentation of the past president's pin.

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This course will be given annually, the first session to be from Monday, September 25, through Friday, September 29, 1950. The tuition fee will be \$100.00 to physicians in general; alumni of the Graduate School of Medicine are exempt and pay only a registration fee of \$10.00. All fees are payable on application. Full information and application forms may be obtained through the Office of the Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia 4, Pennsylvania.



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Convention announcements—Mrs. Hugh Robertson.
Adjournment by 11 a.m.

11:15 a.m.

Buses load for trip to Kennett Square and Longwood Gardens.

12:45 p.m.

Luncheon—Kennett Square Country Club, in honor of Mrs. Howard H. Hamman.

Hostesses—Woman's Auxiliary to Chester County Medical Society.

2:00 p.m.

Visit to DuPont estate at Longwood Gardens.

9:00 p.m.

President's Reception—Ballroom, Bellevue-Stratford Hotel. In honor of Harold B. Gardner, M.D., president of The Medical Society of the State of Pennsylvania.

Dancing to Clarence Fuhrman's KYW Orchestra.

Thursday, October 19

9:00 a.m.

Breakfast.

Post-convention Executive Board meeting, Mrs. Howard H. Hamman, presiding. (All members of the Executive Board are urged to be present.)

Announcement of committee appointments.

Election of Executive Board delegates to 1951 national convention.

Election of nominating committee for 1950-51.

Presentation of program for 1950-51.

Plans for work of standing committee chairmen.

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MEDICAL NEWS

Engagements

MISS POLLY REYNOLDS WHEATON, of Kingston, to Bruce M. Wimer, M.D., of Philadelphia.

MRS. MARTHA THOMAS LYTLE, of Asheville, N. C., to John Robinson Hoskins, 3d, M.D., of West Chester.

MISS JEAN GARDINER FERGUSON, daughter of Mrs. L. Kraer Ferguson, of Penn Valley, and Dr. L. Kraer Ferguson, of Philadelphia, to Mr. T. Leonard Shephard, of Penn Valley.

Marriages

MISS EVELYN BAERINGER to Mr. Robert D. Kutteroff, son of Dr. and Mrs. Charles F. Kutteroff, all of Philadelphia, August 26.

MISS ELIZABETH THROCKMORTON JOHNSON, daughter of Dr. and Mrs. William T. Johnson, of Swarthmore, to Mr. Richard Bowman Wray, also of Swarthmore, August 26.

MISS KATHERINE TABB KUNKEL, daughter of Mrs. John C. Kunkel and the late Dr. W. Minster Kunkel, of Harrisburg, to Mr. Kenneth Riley Stark, Jr., also of Harrisburg, July 29.

MISS ROSE JOHANNA SWOYER, daughter of the Rev. Dr. and Mrs. Grover E. Swoyer, of Pittsburgh, to J. Van S. Donaldson, M.D., of Butler, son of Dr. and Mrs. Walter F. Donaldson, of Pittsburgh, August 26.

MARGARET M. LYMAN, M.D., of Norfolk, Conn., to William J. Williams, M.D., of Bridgeton, N. J., August 12. The bride is a resident at the Children's Hospital of Philadelphia, and the groom is doing research work at the University Hospital. Both are graduates of the University of Pennsylvania School of Medicine.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ Robert F. Ridpath, Philadelphia; Medico-Chirurgical College of Philadelphia, 1899; aged 74; died Aug. 10, 1950, at his home in Cape May, N. J. Dr. Ridpath was emeritus professor of otorhinolaryngology at Temple University Medical School and associate professor of laryngology at the Graduate School of Medicine, University of Pennsylvania. He was consultant at Graduate Hospital, Jewish Hospital, and Skin and Cancer Hospital, Philadelphia, and at Riverview Hospital, Norristown. At one time he was chairman of the AMA's section on otolaryngology. He was a Fellow of the American College of Surgeons and a member of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological Association, the American Laryngological, Rhinological, and Otolological Society, Inc., and the American Bron-

cho-esophagological Association. Surviving are his widow, a son, and three sisters.

○ Patrick E. Biggins, Sharpville; Medico-Chirurgical College of Philadelphia, 1907; aged 70; died Aug. 19, 1950, after a short illness. Dr. Biggins was considered one of the foremost heart specialists in his area. He served in the Army Medical Corps during World War I, and later became one of the first commanders of the Sharpville American Legion post. He was a past president of the Mercer County Medical Society and of the Association of Surgeons of the Pennsylvania Railroad. During World War II he served as acting coroner of Mercer County, substituting for his son, James A. Biggins, M.D., who was in service as a flight surgeon. A son, Edward, was one of the first American soldiers to lose his life in the African campaign of World War II. Surviving besides his son, Dr. Biggins, are three other sons and three daughters.

○ Frank H. Rimer, Pittsburgh; University of Pittsburgh School of Medicine, 1911; aged 71; died Aug. 3, 1950. At one time he served as chief of medical service at Municipal Hospital and later became superintendent. He left Municipal Hospital to become a staff member at Mercy Hospital where he remained until 1947, when he resigned because of ill health. Dr. Rimer was a member of the American Academy of Ophthalmology and Otolaryngology. He was a veteran of the Spanish-American War. Surviving are his widow, two sisters, and three brothers.

○ William J. Killius, Johnstown; Medical College of Virginia, Richmond, 1926; aged 54; died Aug. 3, 1950, following an operation on July 27. A medical corps reservist from World War I days, Dr. Killius also served in World War II as registrar at a base hospital and as a medical examiner for the army recruiting service and also for the U. S. Civil Service. He left the service in 1945 with the rank of major. In 1949 he was named physician in charge of the Johnstown Regional Red Cross Blood Center. His widow survives him.

○ William A. Swalm, Philadelphia; University of Pennsylvania School of Medicine, 1911; aged 62; died Aug. 11, 1950, following a heart attack. Dr. Swalm was associate professor of medicine at Temple University School of Medicine and the author of numerous pamphlets and articles published in the *Cyclopedia of Medicine*. He was a Fellow of the American College of Physicians and a member of the American Gastroenterological Association. Surviving are his widow and a son.

○ Thomas C. Rutter, Schuylkill Haven; University of Pennsylvania School of Medicine, 1900; aged 76, died Aug. 14, 1950, following a heart attack. Dr. Rutter was also a graduate of the Philadelphia College of Pharmacy. In April he was honored by the State Med-

ical Society in recognition of his 50 years spent in the practice of medicine. He is survived by his widow, two daughters, and two sisters.

○ James M. Long, Norwalk, Conn.; Columbia University College of Physicians and Surgeons, New York, 1904; aged 73; died July 31, 1950. A member of Allegheny County Medical Society, Dr. Long retired three years ago, at which time he moved to Connecticut. While in Pittsburgh he was associated with the Allegheny General Hospital. He is survived by his widow and two daughters.

○ James R. McNinch, West Alexander; Eclectic Medical College, Cincinnati, Ohio, 1901; aged 75; died in Wheeling, W. Va., Aug. 16, 1950, following a coronary attack. Surviving are his widow, two sons, Dr. Eugene McNinch and Dr. James R. McNinch, Jr., both associated with University Hospital, Baltimore, Md., and a sister.

○ William H. Meminger, Altoona; Medico-Chirurgical College of Philadelphia, 1906; aged 69; died Aug. 7, 1950, after a year's illness. He is survived by his widow and two sons.

○ James D. Beach, Williamsport; Jefferson Medical College of Philadelphia, 1895; aged 80; died July 3, 1950.

○ Harry H. Miller, Johnstown; Eclectic Medical College, Cincinnati, Ohio, 1902; aged 78; died July 3, 1950.

Samuel H. Craig, Philadelphia; Jefferson Medical College of Philadelphia, 1910; aged 73; died Aug. 9, 1950.

Miscellaneous

KENNETH M. DAY, M.D., of Pittsburgh, associate professor of otology at the University of Pittsburgh School of Medicine, is the current president of the American Otological Society.

THE THIRD ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF BLOOD BANKS will be held October 12 to 14 at the Stevens Hotel in Chicago. Details of the program can be obtained from the association's office at 3301 Junius St., Dallas, Texas.

DRS. W. WAYNE BABCOCK AND HARRY E. BACON, of Philadelphia, have received the honorary degree of science from the faculties of medicine of several Argentina universities. The degrees were conferred during a meeting of the International Surgical Congress in Buenos Aires in "recognition of their surgical achievement on behalf of mankind."

THE AMERICAN ACADEMY OF ALLERGY is offering a postgraduate course in allergy, sponsored by the faculty of McGill University in Montreal, on October 26 to 28. There is a registration fee of \$40 for the course, and applications and requests for additional information

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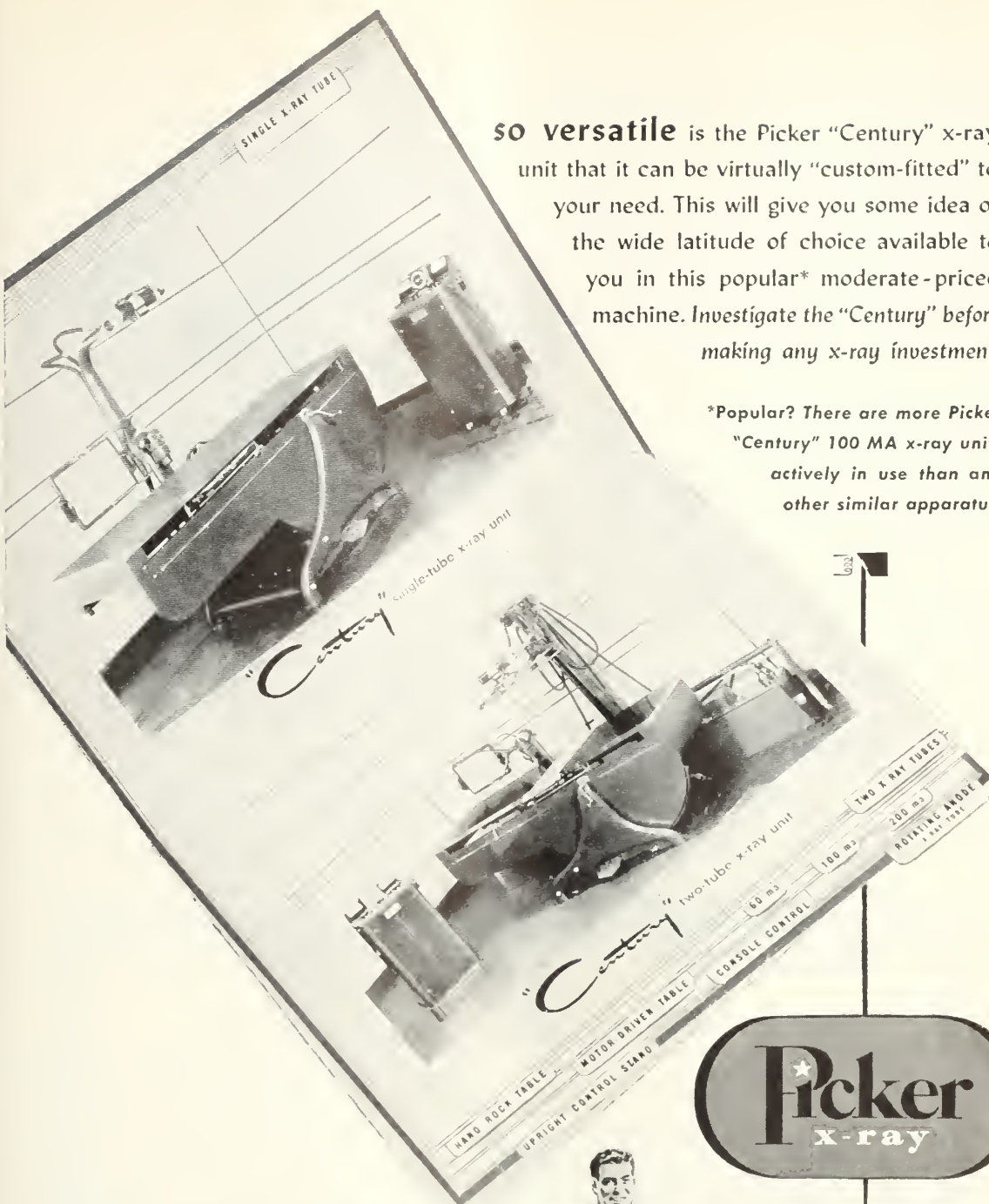
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IN 1951 THE \$25 DUES OF THE AMERICAN MEDICAL ASSOCIATION will include a subscription to the *Journal of the AMA* or one of the specialty journals. In effect, this practically cuts the dues in half, as the subscription price of the *Journal* at the present time is \$12, which will, on a separate subscription basis, be increased next year to \$15. AMA Fellowship dues have been reduced from \$12 to \$2.00 annually.

FOUR HUNDRED NEIGHBORS AND FRIENDS OF JOHN DALE GREAVES, M.D., of New Alexandria, gave him a testimonial dinner last month in celebration of his 50 years in the general practice of medicine. The affair, arranged by a committee of friends, was marked, according to the *Greensburg Tribune*, by spontaneous plaudits from dozens of persons, with more extended remarks by clergymen and the president of the Westmoreland County Medical Society. Dr. Greaves, after his re-

sponse, was presented with a watch and Mrs. Greaves with a necklace.

THE COUNCIL ON POSTGRADUATE MEDICAL EDUCATION of the American College of Chest Physicians announces that it will sponsor a postgraduate course in Recent Advances in Diseases of the Chest at the Hotel New Yorker, New York City, November 13 to 18. Tuition for the course is \$50. Applications will be accepted in the order in which they are received, as registration will be limited. Address all inquiries and applications to the Council on Postgraduate Medical Education, 500 North Dearborn St., Chicago 10, Ill.

HENRY A. SLOVITER, M.D., who recently completed his internship at the University of Pennsylvania Hospital in Philadelphia, has been awarded a Damon Runyon senior clinical research fellowship by the American Cancer Society. He will leave for London this month to spend a year there at the National Institute for Medical Research, where he expects to study the survival and revival of the reproductive sperm cells, since the American Cancer Society wants to develop all possible information concerning the fundamental growth processes in their relation to the possible causes of cancer.

ON JULY 14 THE COLLEGE OF PHYSICIANS OF PHILADELPHIA awarded the Alvarenga Prize for 1950 to Ephraim Shorr, M.D., associate professor of medicine, Cornell University Medical College, for his outstanding work in shock which has provided a clearer understanding of the mechanism of this important condition.

The Alvarenga Prize was established by the will of Pedro Francesco DaCosta Alvarenga of Lisbon, Portugal, an associate fellow of the College of Physicians of Philadelphia, to be awarded annually by the College of Physicians on the anniversary of the death of the testator, July 14, 1883.

THE AMERICAN UROLOGICAL ASSOCIATION offers an annual award of \$1,000 (first prize \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, Ill., May 21-24, 1951.

For full particulars write the secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, N. J. Essays must be in his hands before Feb. 10, 1951.

Postgraduate Course

AT

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Another postgraduate course in Cardiology will be given during the coming winter. Starting in October, on Thursday afternoons from 2:00 to 5:00, thirty sessions will be held. Modern diagnosis and treatment of various forms of heart disease will be discussed. Registration is limited and individual instruction will be emphasized.

Detailed information will be forwarded upon request to Dr. George D. Geckeler, Hahnemann Hospital, Philadelphia 2. Early registration is suggested.

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Position Wanted.—Technician experienced in clinical laboratory work. References. Write Dept. 219, PENNSYLVANIA MEDICAL JOURNAL.

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For Sale.—Instruments, books, and office equipment of recently deceased physician who did general practice and eye, ear, nose and throat work. Write MRS. L. N. REICHARD, 306 Front St., Brownsville, Pa.

Wanted.—Physician licensed in Pennsylvania qualified to take over as Director of Anesthesiology in approved general hospital in Pittsburgh. Salary open. Write Dept. 212, PENNSYLVANIA MEDICAL JOURNAL.

Locum Tenens.—Choice general practice ("Office hours—By Appointment Only" type) with active records on approximately 5300 patients open September 20, 1950 to June 1, 1951, in northwestern Pennsylvania community of 60,000 people. Fully equipped office suite of six rooms. Ideal financial set-up for doctor awaiting 1951 residency. Write Dept. 213, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Pathologist, diplomate or qualified for board examinations, to associate with and succeed present director who is retiring soon. Modern, approved, 200-bed hospital. Write WASHINGTON HOSPITAL, Washington, Pa.

Wanted.—Young doctor, Pennsylvania license, to assist in office Oct. 1, 1950 through Dec. 31, 1950 while partner is doing graduate work. Western Pennsylvania town of 4500. Write Dept. 210, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—General practitioner for community near Washington, Pennsylvania. Office, equipment, housing made available. Offers attractive future. Willing to discuss yearly guarantee. Write MR. WILLIS L. KENNEDY, Washington and Jefferson College, Washington, Pa.

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Opportunities for Physicians.—Are you interested in a position in one of our county or district health departments? Salary \$5,600 to \$7,200 with \$70 a month travel allowance. Public health scholarships available with liberal stipends. Men and women physicians eligible. Write FELIX J. UNDERWOOD, M.D., Mississippi State Board of Health, Jackson, Miss.

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For Sale.—Doctor's residence with fully equipped offices at 612 West Market St., Pottsville, Pa. For sale because of death. Well-established ophthalmologic practice. Excellent opportunity. Write Mr. F. C. MENGEL, 38 St. John St., Schuylkill Haven, Pa.

For Sale.—Combination home and office. Small town in eastern Pennsylvania. Some industrial work with salary. Other contacts available. Immediate possession. Good reason for selling. Excellent opportunity for young man. Price reasonable. Write Dept. 209, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Lucrative practice in community of 6000, located 18 miles from Wilkes-Barre, Pa. Hospitals ten miles distant. Small investment only for equipment and drugs. Very reasonable office and home rental. Specializing. Write Dept. 217, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—General practice with all supplies and equipment for price of equipment alone; includes 100 KV, 100 MA x-ray and fluoroscopic unit with all accessories. Office suite of six rooms in central location of small industrial community 30 miles west of Philadelphia. Price, \$5,000. Write Dept. 183, PENNSYLVANIA MEDICAL JOURNAL.

Wanted at Once.—Physician with Pennsylvania license for general and industrial bituminous mining practice. Near general hospital. Salary \$800 to \$1,500 a month. No investment needed. House available. Desirable community. Contact F. J. KELLAM, M.D., Indiana, Pa., Telephone—Indiana 374. (50 miles north of Pittsburgh.)

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Wanted.—General practitioner for town of McAlisterville. Located in Juniata County in agriculture and hatching section. Population of 600 with surrounding area including approximately 3000 persons. Civic leaders very interested in securing physician. New house available. For further information contact Mr. WAYNE W. GOODLING, McAlisterville Shoe Store, McAlisterville, Pa.

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BOOK REVIEWS

Medical State Board Questions and Answers. By R. Max Goepf, M.D., formerly Professor of Clinical Medicine, Graduate School of the University of Pennsylvania, and Professor of Medicine, Woman's Medical College of Pennsylvania, and Harrison F. Flippin, M.D., Associate Professor of Medicine, Graduate School of Medicine of the University of Pennsylvania. Eighth edition. Philadelphia: W. B. Saunders Company, 1950. Price, \$7.00.

This edition has come to fruition eleven years after the seventh and was motivated by the many advances made in the various fields of medicine. The text is divided into the following phases: anatomy, physiology, physiologic chemistry, pathology, bacteriology, materia medica and therapeutics, practice of medicine, surgery, obstetrics and gynecology, hygiene, and medical jurisprudence. Each section is treated in the same manner. Representative questions and comprehensive answers are the keynote throughout.

Anyone preparing for state board examinations should find this volume an excellent aid for review and crystallizing salient information.

Tuberculosis. A Global Study in Social Pathology. By John B. McDougall, C.B.E., M.D., F.R.C.P. (Edin.), F.R.F.P.S. (Glas.), F.R.S.E. (Section of Tuberculosis, World Health Organization); Honorary Medical Adviser to the British Legion Village, Preston Hall, Kent, England. (Formerly Medical Superintendent, Crossley Sanatorium, Delamere Forest, Cheshire; and Woolley Sanatorium, Hexham, Northumberland; Director, Preston Hall Village Settlement, Maidstone, Kent; Nayland Sanatorium, Colchester and Douglas House, Bournemouth. From 1944 to 1947, adviser in tuberculosis to UNRRA in Greece.) Baltimore: The Williams & Wilkins Company, 1949. Price, \$6.00.

This excellent treatise on the epidemiology of tuberculosis has two purposes: the first, the presentation of information on infection, morbidity, and mortality from tuberculosis; and second, an analysis of factors usually considered to have a bearing on the extent and severity of the problem in communities. The book is divided into four sections: (1) mortality rates and other data concerning tuberculosis in different countries of the world; (2) a careful evaluation of the various factors affecting morbidity and mortality rates of tuberculosis; (3) investigating the tuberculosis problem in a community; and (4) a general discussion of the en-

tire tuberculosis situation with a summary of the salient features of all preceding chapters.

Dr. McDougall has collected a wealth of detail on tuberculosis mortality rates throughout the world and his full and complete discussion of the fundamental factors influencing the development of this disease makes the book a most valuable reference work. The chapters on BCG and on native and acquired resistance are of special excellence.

Possibly some of the detailed statistics of tuberculosis morbidity and mortality rates of countries where vital statistics are admittedly unreliable or inaccurate could be abbreviated or omitted, and there is a tendency for repetition of such phases as mass x-ray surveys and BCG. These are minor criticisms, however. The book can be highly recommended and should be studied by all those interested in public health. It is a "must" for all students of tuberculosis.

Textbook of Endocrinology. Edited by Robert H. Williams, M.D., Executive Officer and Professor of Medicine, University of Washington Medical School, Seattle. With the collaboration of Peter H. Forsham, Harry B. Friedgood, John Eager Howard, Edwin J. Kepler, William Locke, L. Harry Newburgh, Edward C. Reifenshtein, Jr., William W. Scott, George Van S. Smith, George W. Thorn, and Lawson Wilkins. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$10.00.

During the past two decades the advances in endocrinology have been so rapid that the physician and student have found it rather difficult not only to assimilate current information in this field but to put into practice an integrated program for diagnosis and therapy. With this problem in mind the editor, aided by eleven outstanding authorities, has presented a text filled with comprehensive discussions on the clinical management of endocrinopathies. This material is based upon the application of fundamental information obtained from biochemical and physiologic studies. In addition, revealing light has been focused on the influence of hormones in non-endocrine problems such as cardiac, hypertensive, neoplastic, and collagen diseases.

The text is well organized and divided into twelve chapters covering all the endocrine glands plus an excellent section on the neuro-endocrine and psychodynamic aspects of the endocrinopathies; also one on assay and diagnostic laboratory procedures. Throughout the reader will find pictures representative of various entities under discussion.

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ASK TO BE PLACED ON OUR MAILING LIST FOR ALL NEW MEDICAL AND ALLIED BOOKS

This book is recommended for its clarity of presentation as well as accumulated mass of factual information.

Current Therapy, 1950. Latest approved methods of treatment for the practicing physician. Editor, Howard F. Conn, M.D. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, and Robert H. Williams. 736 pages. Philadelphia: W. B. Saunders Company, 1950. Price, \$10.00.

This book presents a record of the current treatment procedures as practiced by the more than 250 contributors. The practitioner will find all of the information he needs to treat the variety of disease manifestations which confront him. In some instances where there are two or more methods of treating a disorder, each is included without a preference being indicated.

This current edition follows the arrangement of the original volume published in 1949. Sixteen new subjects have been added with a new section on diseases of the locomotor system. The section on infectious diseases has been completely revised to include the latest chemotherapeutic advances.

The contents are arranged into fifteen sections, each of which has a separate table of contents in addition to the general table of contents. Thus, with the aid of a comprehensive index, the reader can locate information very quickly.

This book is recommended as a valuable reference guide to the latest methods of treatment.

The Merck Manual of Diagnosis and Therapy. A source of ready reference for the physician. Rahway, N. J.: Merck & Company, Inc., 1950. Price, regular edition, \$4.50; thumb-index edition, \$5.00.

This new eighth edition of the *Merck Manual* surpasses all previous editions. Eighty-two new chapters have been added by the one hundred clinicians who served as authors or consultants.

New or expanded chapters include those on nutritional deficiencies, radiation reactions and injuries (including those due to atomic bombs), allergies, and anti-histamines, psychoneuroses, drug addiction, dental emergencies that the physician may have to treat, prenatal and postnatal care, and the care of premature infants.

More than 1175 prescriptions are included, conveniently arranged in categories according to therapeutic action. Included also are new chapters on routine immunization measures, clinical and bedside procedures, suggested items for the physician's bag, a section on diets, and helpful ready-reference data and conversion data.

A few of the highlights are chapters on antibiotic therapy, including details of treatment with streptomycin and dihydrostreptomycin, aureomycin, chloromycetin and bacitracin; the use of crystalline vitamin B₁₂, the pure anti-anemia factor, and cortisone and ACTH. The latest clinical results to date are cited for these new drugs and chemicals.

A time-saving index, greatly expanded and liberally cross-titled, is provided. This book is truly "a source of ready reference for the physician."

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

A Textbook of Gynecology. By Arthur Hale Curtis, M.D., Emeritus Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; formerly Chief of Gynecologic Service, Passavant Memorial Hospital, Chicago; and John William Huffman, M.D., Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School; Attending Gynecologist, Passavant Memorial Hospital, Chicago. Sixth edition with 466 illustrations, chiefly by Tom Jones, including 37 in color. Philadelphia: W. B. Saunders Company, 1950. Price, \$10.00.

Medical Diagnosis. Applied Physical Diagnosis. Edited by Roscoe L. Pullen, M.D., F.A.C.P., Professor of Graduate Medicine, Director of the Division of Graduate Medicine, and Vice Dean of the School of Medicine, Tulane University of Louisiana; Senior Visiting Physician, Charity Hospital of Louisiana at New Orleans; Consultant in Medicine, Veterans Administration Hospital, New Orleans, La.; Consultant to the Surgeon General, Department of the Army, Washington, D. C. Second edition with 601 figures, 48 in color. Philadelphia: W. B. Saunders Company, 1950. Price, \$12.50.

A Textbook of X-ray Diagnosis. By British authors in four volumes. Second edition edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director, X-Ray Diagnostic Department, University College Hospital, London, and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Director, X-Ray Department, Westminster Hospital; Radiologist, Royal Chest Hospital, London. Volume IV with 553 illustrations. Philadelphia and London: W. B. Saunders Company, 1950. Price, \$15.00.

Techniques in British Surgery. Edited by Rodney Maingot, F.R.C.S. Illustrated. Philadelphia and London: W. B. Saunders Company, 1950. Price, \$15.00.

Plastic and Reconstructive Surgery. A Manual of Management. By Ferris Smith, M.D., F.A.C.S., Consultant in Plastic Surgery, Blodgett Memorial Hospital, Grand Rapids, Mich. Philadelphia and London: W. B. Saunders Company, 1950. Price, \$15.00.

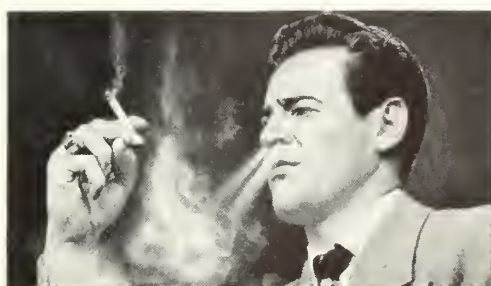
The Urinary Function of the Kidney. By A. V. Wolf, Ph.D., Associate Professor of Physiology, Albany Medical College, Union University. New York: Grune & Stratton, Inc., 1950. Price, \$7.50.

Progress in Neurology and Psychiatry. An Annual Review. Volume V. Edited by E. A. Spiegel, M.D., Professor and Head of the Department of Experimental Neurology, Temple University School of Medicine, Philadelphia, Pa. New York: Grune & Stratton, 1950.



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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

Nursing in Prevention and Control of Tuberculosis. By H. W. Hetherington, M.D., M.R.C.P. (London), Chief of Clinic of the Henry Phipps Institute of the University of Pennsylvania; Assistant Professor of Medicine at the University of Pennsylvania School of Medicine; former Visiting Physician to the White Haven Sanatorium; and Fannie W. Eshleman, R.N.,

B.S., Supervisor of Public Health Nursing at the Henry Phipps Institute of the University of Pennsylvania; Lecturer on Tuberculosis Nursing, Department of Nursing Education of the University of Pennsylvania. Illustrated with photographs and charts. Revised third edition. New York: G. P. Putnam's Sons, 1950. Price, \$4.50.

VIRUS DIAGNOSTIC LABORATORY

Free Services to Physicians

In the interest of spreading information to all physicians practicing in the Keystone State, the JOURNAL is glad to publish evidence of a fine diagnostic service freely available for the benefit of patients in or out of medical institutions.

The appended chart is illustrative of the breadth of the diagnostic service on virus and rickettsial diseases by the Reference Laboratory for the Pennsylvania Department of Health in Philadelphia. The Virus Diagnostic Laboratory is a section of the Division of Virology in the Department of Public Health and Preventive Medicine of the University of Pennsylvania School of Medicine. Similar reports will appear in the PENNSYLVANIA MEDICAL JOURNAL at intervals with the hope that Pennsylvania people in every county will be benefited. (EDITOR'S NOTE: See page 631 of the June, 1950 issue for the first of these reports.)

VIRUS DIAGNOSTIC LABORATORY

Reference Laboratory for the Department of Health
Commonwealth of Pennsylvania

REPORT OF DIAGNOSTIC ACTIVITIES FOR THE MONTHS OF MARCH, APRIL, AND MAY, 1950

Number of specimens	728
Number of patients	443
Number of tests	4395

Breakdown

Positive Laboratory Findings*

Place from which specimen was sent	Total patients	Disease Suspected				
		Neurologic	Respiratory	Mumps	Lymphogranuloma	Newcastle
Philadelphia †	84	15 (LCM-2, mumps-11, toxoplasmosis-2)	44 (CA-8, influenza-36)	19	5	1
Pittsburgh	5	4 mumps	1 psittacosis- LGV	0	0	0
Chester	2	2 (LCM-1, mumps-1)	0	0	0	0
Camden, N. J.	2	0	2 (CA-1, influenza-1)	0	0	0
Wilmington, Del. ..	3	0	3 influenza	0	0	0
Others ‡	8	4 mumps	2 (CA-1, psittacosis-1)	2	0	0
Total	104	25	52	21	5	1

* Tests could not be completed on 136 patients (primarily because of lack of appropriate specimens).

† Includes patients in Philadelphia hospitals; the town of residence of these patients is usually unknown to this laboratory.

‡ Includes one or two specimens from each of the following communities: Chester, N. Y.; Bryn Mawr, Abington, Lansdowne, Upper Darby, Norristown, Pa.; Cincinnati, Ohio; and Toronto, Canada.

Key to abbreviations: LCM—lymphocytic choriomeningitis; CA—cold agglutination; LGV—lymphogranuloma venereum.



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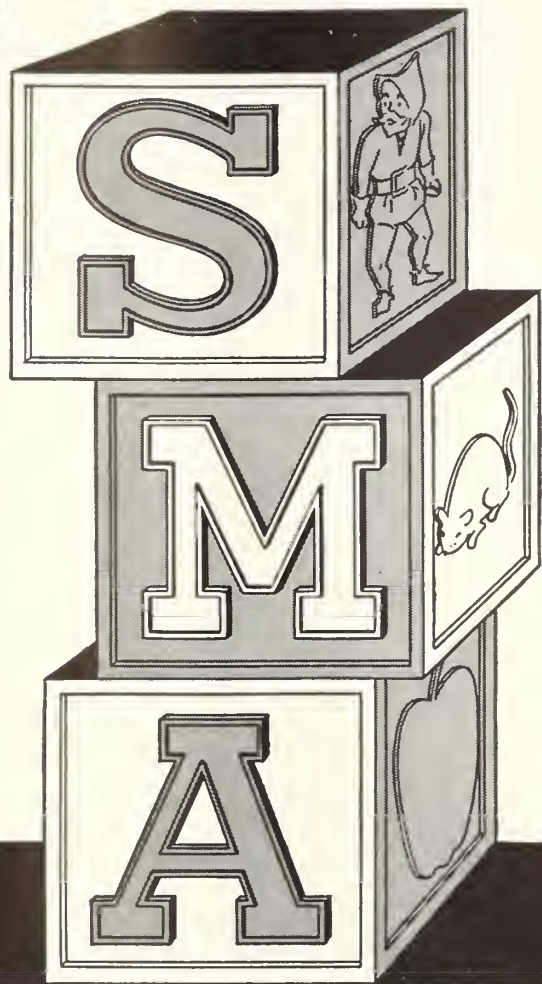
Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

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Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.



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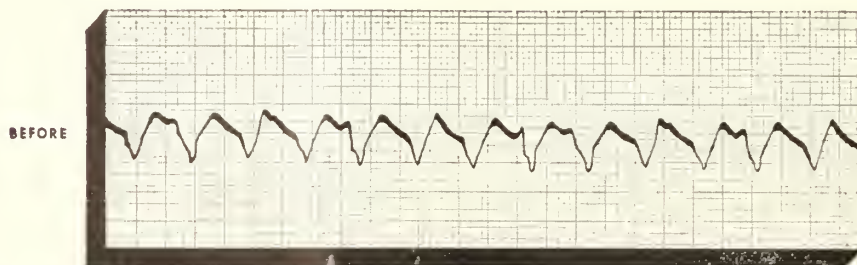
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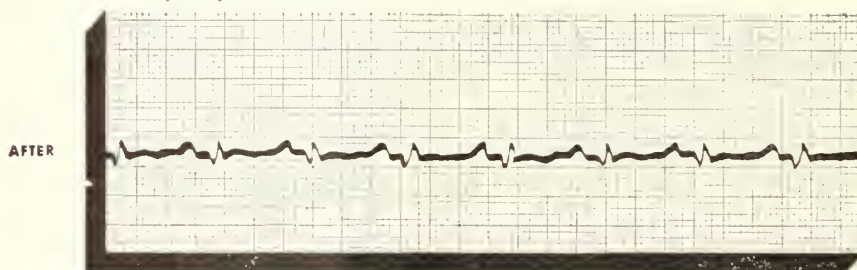
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When is it indicated?

In conscious patients, for the treatment of ventricular arrhythmias.

During anesthesia, to correct cardiac arrhythmias.

What are its advantages in ventricular arrhythmias?

As compared with quinidine: Unlike quinidine, no important toxic symptoms have been reported following the use of Pronestyl orally. In therapeutic dosage, Pronestyl orally does not produce the nausea, vomiting, and diarrhea often caused by quinidine. At high oral dosage, these symptoms may appear.

Whereas intravenous administration of quinidine is hazardous and unpredictable, Pronestyl may be given intravenously with relative safety.

Pronestyl has been found effective in some patients who failed to respond to quinidine.

As compared with procaine: For arrhythmias, procaine is used only in anesthetized patients because its dose in unanesthetized patients is too toxic for clinical use. Pronestyl can be used in conscious and anesthetized patients.

Intravenously, Pronestyl is much less toxic than procaine. In the recommended intravenous dosage, Pronestyl does not cause the central nervous system stimulation typical of procaine in conscious patients.

Procaine is unstable, being rapidly hydrolyzed in the plasma to para-aminobenzoic acid and diethylaminoethanol. Pronestyl is not affected by the plasma procaine esterase, consequently it is much longer acting than procaine.

Procaine is not used orally because of its instability in the organism; Pronestyl can be used orally and intravenously.

What are its side effects?

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evi-

denced by studies of the blood count, urine, liver function, blood pressure, and electrocardiogram. Intravenous administration to patients without ventricular tachycardia produced only a moderate and transient hypotensive effect in about one-third of the subjects. However, during intravenous administration to patients with ventricular tachycardia, a striking hypotensive effect was almost invariably present. This disappeared concurrently with the establishment of a normal rhythm. Further studies are in progress to see whether the drug may be given intravenously over a period of time longer than five minutes so as to revert the ventricular tachycardia without causing hypotension. That this may be possible is indicated by the fact that some episodes of ventricular tachycardia have been successfully treated by oral administration without significant change in blood pressure. Electrocardiographic changes: prolongation of QRS and QT intervals and occasional diminution in voltage of QRS and T waves have occurred.

What is the dosage?

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia:

ORALLY: 1 Gm. followed by 0.5-1.0 Gm. every four to six hours as indicated.

INTRAVENOUSLY: 200-1000 mg. (2 to 10 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. If marked hypotension occurs, rate of injection should be slowed or stopped.

For the treatment of runs of ventricular extrasystoles:

ORALLY: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias:

INTRAVENOUSLY: 100-500 mg. (1 to 5 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

How is it supplied?

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.

Pronestyl Hydrochloride Solution, 100 mg. per cc., in 10 cc. vials.



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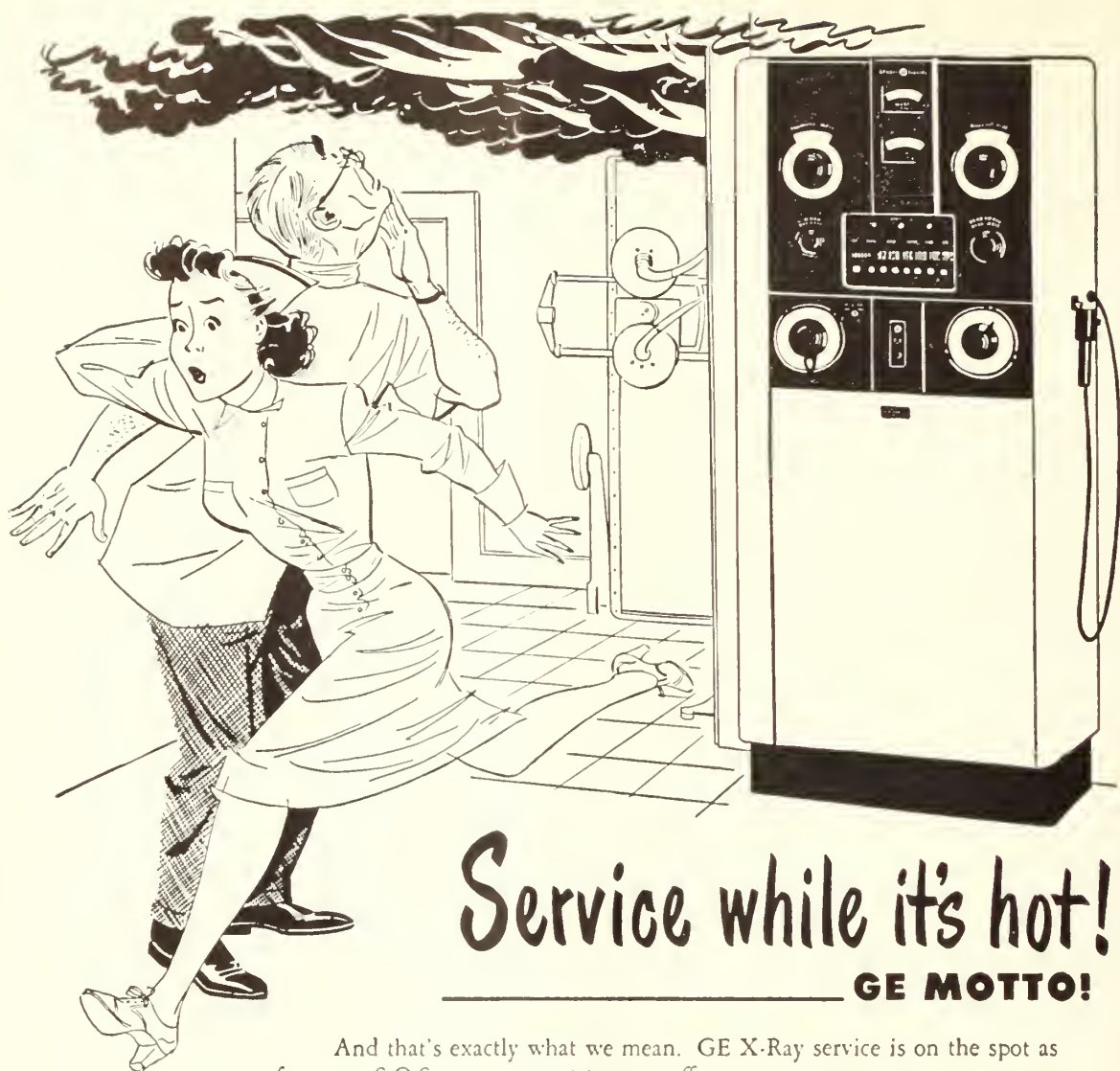


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1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.

2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950

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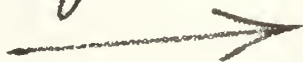


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1. Internat. Abstr. Surg. 83:1, July 1946.
2. Am. J. Obst. & Gynec. 49:114, Jan. 1945.
3. J.A.M.A. 128:1152, Aug. 18, 1945.

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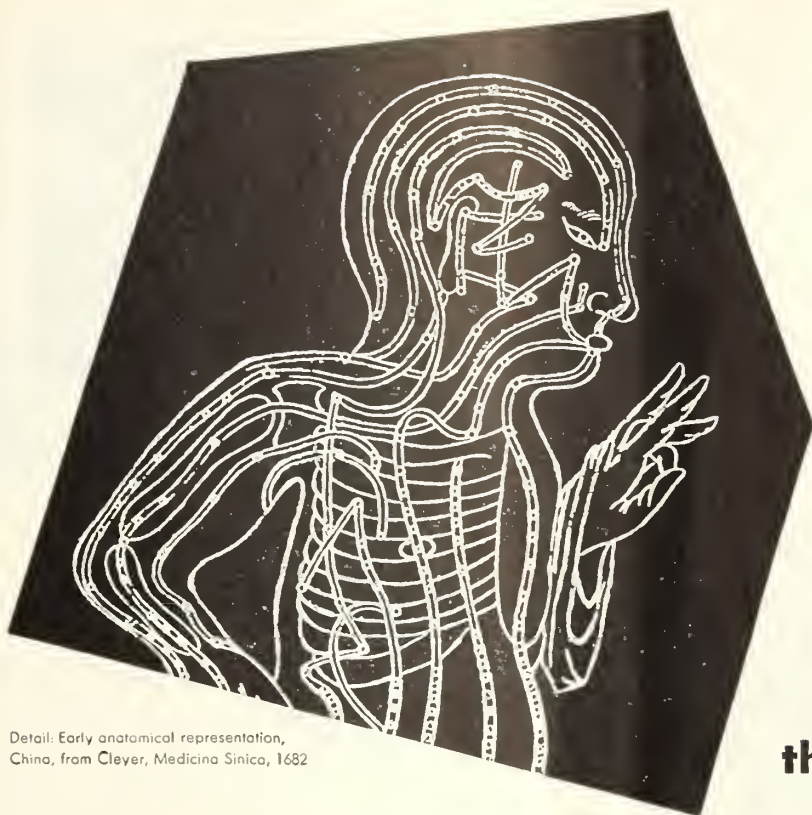
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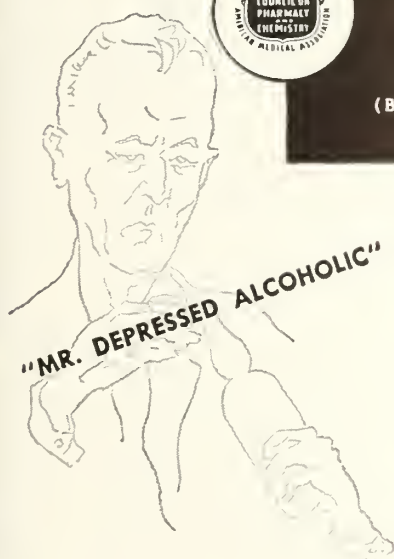


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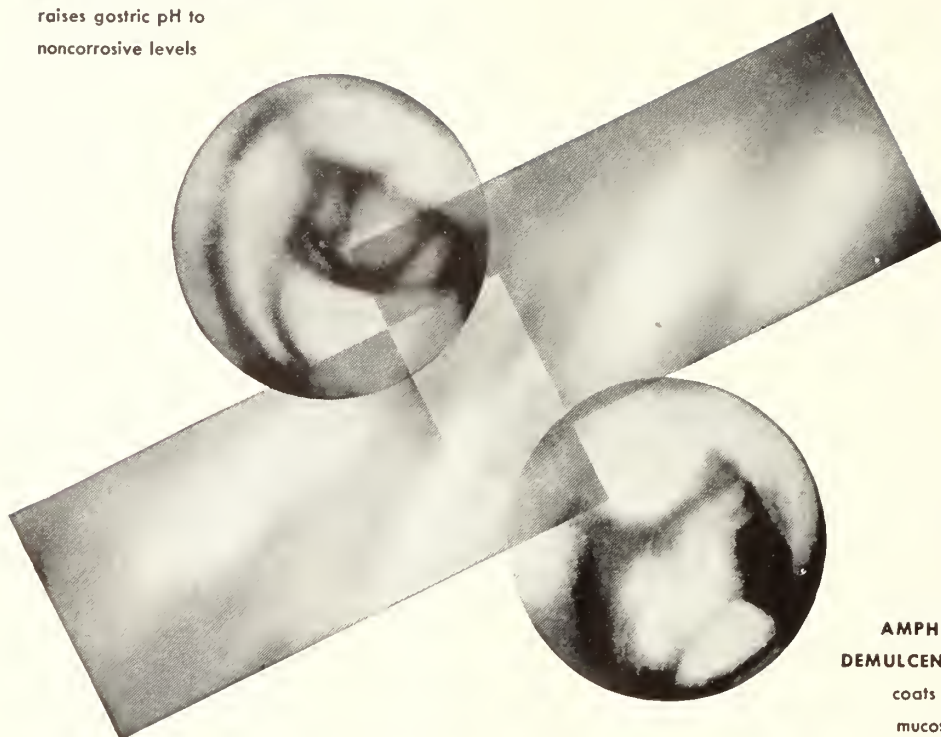
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HEMOCHROMATOSIS

A Review of the Literature

JOSEPH C. DOANE, M.D., CHARLES H. KRAVITZ, M.D.,
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TROUSSEAU first described this disease in 1865, and Hanot and Chauffard gave it the name of bronze diabetes in 1882.¹ In 1889 von Recklinghausen described the two pigments, hemosiderin and hemofuscin, present in hemochromatosis.²

It is said that this condition develops in approximately one in 5000 diabetics, and it may well be that a physician may never meet a case in his medical lifetime. This disease, like many others, however, will be recognized more frequently if a high index of suspicion is constantly maintained.

Pathophysiology

Hemochromatosis is a chronic disease which is "characterized by the presence of two pigments in the cells of various organs and tissues of the body. One of the pigments, hemosiderin, gives a reaction for iron, the other, hemofuscin, does not."³

In order to better appreciate the various pigments concerned with hemochromatosis, a brief review of the newer concepts of iron metabolism seems appropriate.

The iron compounds of the body are divided into two groups: (1) the iron porphyrin or heme compounds, and (2) the non-heme iron compounds. The heme compounds, when associated with specific proteins, are the means of providing oxygen to the body cells. The chief compounds are hemoglobin and myoglobin. The iron in the hemoglobin of the red cell and of muscle amounts to 65 to 75 per cent of the total body iron. The non-heme compounds are made up of two classes. The first includes ferrous iron and siderophyllin, which is a serum globulin and is the transport form of iron in the blood stream; the second class contains iron in the form of ferric hydroxide units, mainly ferritin, non-crystallizable ferritin, and hemosiderin. The last three compounds are the storage forms of iron.

Iron may exist in the body in two forms of oxidation, either the ferrous or ferric state. Siderophyllin is a pseudoglobulin that can carry two iron atoms in the ferric state. Ferritin is a brown iron containing protein whose primary function is that of iron storage. Many different tissues seem to be able to make ferritin including the spleen, liver, and bone marrow. A second function of ferritin is the regulation of iron absorption. Recently, Mazur and Shorr¹⁶ have

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shown that ferritin may inhibit the vasoconstrictor action of adrenalin and thus it may be implicated in the shock picture. Hemosiderin is a substance composed of clusters of iron hydroxide mixed with some protein, and this is microscopically visible in contrast to the invisible ferritin. One can picture hemosiderin as the abnormal storage of iron deposition beyond that of ferritin.

Cantarow and Trumper¹⁷ point out that iron is absorbed from the gastro-intestinal tract in the form of ferrous salts and is transported in the plasma as the ferric iron. Iron that is absorbed remains in the body and is not excreted. The small amount that is lost per day is due to the sloughing off of cells from the gastro-intestinal tract and small amounts in the bile and urine. The absorbed iron is either stored in the liver and tissues or utilized in the formation of hemoglobin.

In hemochromatosis there is a deposition of pigment with resultant fibrotic change and degeneration of cells in the parenchyma of many organs. The physiologic changes produced depend upon the structures involved. The hepatic and the reticulo-endothelial cells of the liver are heavily infiltrated with hemosiderin. This leads to cellular degeneration with a replacement fibrosis and a tremendous increase in the connective tissue of the liver. Consequently, the metabolic functions of the liver are greatly altered. One of the chief defects is an inability to store glucose which is then retained in the blood and lost in the urine. The same pathologic disturbances occur in the pancreas, so that there is a progressive and inevitable destruction of the islands of Langerhans. Beardwood and Rouse⁴ have ascribed the inability to control the extreme lability of the blood sugar to this progressive destructive pathology.

The spleen and bone marrow contain relatively little of the pigment.¹³

The parathyroids may also be infiltrated with pigment and as a result, according to Boyd,⁵ abnormal calcium metabolism and osteoporosis may result. Contributing to the osteoporotic picture are disturbances of the suprarenals and the hypophysis, also secondary to this abnormal pigment deposit. Liver disease which interferes with its ability to act as a depot for vitamin D may contribute to the symptom picture. Another factor in the production of the diabetes may be ascribed to disturbances in the anterior lobe of the pituitary gland. Striated muscle is frequent-

ly the site of excessive pigment deposit, while smooth muscle rarely contains hemosiderin. In 90 per cent of the cases, heavy deposits of iron are found in the heart muscle.⁴ Cardiac hypertrophy frequently occurs. Peculiarly enough, in spite of this high incidence of cardiac involvement, disturbances of the heart function rather rarely are described. One of the most unusual features of a recently observed case was the presence of myocardial infarction. Asthenia and sexual hypoplasia are due to both pituitary and gonadal dysfunction.

Pathogenesis

The chronologic development of the various physiopathologic stages which eventually comprise the disease hemochromatosis is much disputed.

Sheldon⁶ concluded that the disease is due to an inborn error of metabolism with an accumulation of small amounts of pigment over a long period of time, also that this process manifests itself in two ways: (1) by the production of melanin in such structures as the skin and smooth muscle; and (2) by the formation of an iron-containing pigment in nearly all of the tissues.

Mallory³ feels that the cause of hemochromatosis is possibly chronic copper poisoning. He was able to produce the disease in rabbits by feeding them sufficient quantities of copper or its salts. There are many who do not support this belief.

Another theory as to the etiology of this disease is suggested by Zeltmacher and Bevans.⁷ They report a case of aplastic anemia in which hemochromatosis developed after multiple transfusions. Here red cell hemolysis was believed to be the source of iron. In addition, a postulated toxin with hemolytic properties which is the etiologic factor of the aplastic anemia may also serve to liberate free iron. Rous and Oliver⁸ and Muir and Shaw Dunn⁹ were unable to reproduce this sequence experimentally.

Granick¹³ has pointed out that hemochromatosis is a disorder connected with the absorption of abnormally large amounts of iron. He quotes the work of Dubach et al.,¹⁴ who demonstrated this increased iron absorption using radioactive iron. The total amount of iron in the body of an adult is approximately 4 to 5 grams. The liver in hemochromatosis may itself contain 20 to 25 grams of iron. Ordinarily, there is an

absorption of about 1.5 mg. of iron per day from the gastro-intestinal tract. Hence the oral administration of iron in large doses is a highly inefficient and wasteful process since only 10 per cent of ingested iron is absorbed. With a slightly increased absorptive efficiency of 30 per cent for example, as may occur in hemochromatosis, 4.5 mg. could be absorbed per day. This excessive accumulation over a period of two or more decades, in the opinion of Granick,¹³ could produce a storage in the tissues of 30 grams of iron which might result in hemochromatosis. It has never been proved that iron per se in the form of hemosiderin will bring about cell destruction and secondary fibrosis. Instead it is postulated that an abnormal form of iron which is produced through a disturbance of enzyme activity or as a result of some toxic factor in the liver is the etiologic agent which causes the production of hemochromatosis.

That hepatic cirrhosis is the primary disorder which in turn causes a derangement of iron metabolism, and finally hypersideremia, represents another etiologic theory. Gillman and Gillman¹⁰ described the structure of the liver in pellagra. On the basis of liver biopsies in patients with pellagra, these investigators concluded that hemochromatosis is one of the more common sequelae of pellagra. He saw no evidence of increased destruction of blood, and concluded that deposits of hemosiderin and hemofuscin and the increase of copper were the results of disruption of mitochondria.

Taylor, Spiven, and Reid believe that the abnormal iron absorption in the intestinal tract is due to a vitamin A deficiency.

Symptom Complex

The average age of a patient with fully developed hemochromatosis, as quoted by Sheldon,⁶ is 45 to 50 years. The youngest patient was 20 years old. Predominantly, the male sex is afflicted. Lawrence described a family of nine in which two brothers had the disease and, because of this, he suggested the possibility of a sex-linked hereditary factor transmitted by women and affecting men primarily.

The triad of symptoms which comprise this entity are pigmentation of the skin, hepatic cirrhosis, and diabetes mellitus.

Pigmentation of the Skin.—Butt and Wilder¹¹ noted the absence of pigmentation in one of 30 patients studied by them. Pigmentation

may appear late in the disease, but is often present for years before other symptoms appear.¹² The iron-free pigment, hemofuscin, although present in hemochromatosis, is not important in causing skin pigmentation.

Melanin and hemosiderin are the pigments responsible for the change in skin color. Hemosiderin produces a bluish black or lead color in the skin. Melanin causes a brownish color of the skin and probably represents an earlier type of pigmentation. Melanin, by modifying the slate gray of the hemosiderin, produces the classical bronzed appearance. Sheldon⁶ described pigmentation of mucous membranes in 16.7 per cent of his cases. The pigmentation deepens shortly before death and improves under diabetic control.

Cirrhosis of the Liver.—The cirrhosis is characteristically that of an atrophic portal type and the symptomatology may manifest itself before the skin pigmentation is noted by the patient. In the stage of hepatic decompensation, ascites with distended veins of the abdominal wall, spider angiomas, edema of the extremities, esophageal varicosities, and hemorrhoids appear. Cirrhosis of the liver is the outstanding finding of hemochromatosis and one may be justified in making such a diagnosis even in the absence of skin pigmentation and diabetes, provided a liver biopsy reveals iron deposition.

Diabetes.—The last of this triad of outstanding symptoms is diabetes.

The diabetes is fickle, labile, and most difficult to control. Because of the progressiveness of the disease in the pancreas, the diabetic picture becomes worse with the passage of time and is responsible for the extraordinarily large doses of insulin that many cases require. These cases also show a marked fluctuation in the blood sugar curve with frequent hypoglycemic episodes. Terminally, as the destruction of the pancreas becomes more complete, the diabetes is milder and the insulin sensitivity becomes increased. Associated symptoms secondary to a deficit of the non-endocrine pancreatic factors may be present because the acini as well as the insular cells are now involved.

Cantarow and Trumper¹⁷ state that there are "marked fluctuations of glucose tolerance similar to a hypophysectomized depancreatized dog where there is a higher blood sugar after glucose than in a pancreatectomized dog and symptoms of hypoglycemia develop more rapidly and at a

higher blood sugar level than in a hepatectomized dog."

Cardiac complications have been observed in many of these patients, but it is believed that these are not occasioned by the primary disease. Graef, Newman, and Olivett,¹⁸ in a paper read before the American Heart Association meeting at Atlantic City, June, 1949, reported 12 patients with hemochromatosis, seven of whom showed abnormal cardiac function. Four of these had paroxysmal arrhythmias and six had congestive heart failure. The myocardium often shows a large deposition of hemosiderin, but signs of degeneration or fibrosis are infrequent. Knutsen¹⁶ reported two cases of hemochromatosis, one of which suffered a coronary occlusion. In our case an acute myocardial infarction occurred—a rare complication.

Sexual hypoplasia, osteoporosis, and hemeralopia are frequent concurrent findings, and hepatomegaly and splenomegaly are commonly present.

Diagnosis

The diagnosis is reached by an evaluation of the preceding symptoms bolstered by specific laboratory tests, all of which are aimed at demonstrating the presence of hemosiderin deposits. Some of the more common studies consist of: (1) skin biopsy; (2) Rouse's test of urine sediment; (3) examination of the ascitic fluid for iron pigment; (4) Fishback's skin test; and (5) liver biopsy with or without peritoneoscopy.

Treatment

Therapy is most difficult and unsatisfactory because diametrically opposite indications present themselves. The liver involvement requires a high carbohydrate, moderate protein, and fat restricted diet, while the diabetes demands some carbohydrate restriction, particularly since stabilization of the blood sugar is an ever increasing problem. Once the disease becomes sufficiently

advanced that iron pigment deposit in the tissues is widespread, the outcome is uniformly and fairly rapidly fatal. The patient usually succumbs as a result of hepatic, pancreatic, cardiac, or renal insufficiency in from a few weeks to a few months.

Conclusions

1. A discussion of the current trends in our knowledge of the pathophysiology and pathogenesis of hemochromatosis is presented.
2. The diagnostic aspects of this condition from both the clinical and laboratory viewpoints are reviewed.
3. A plea for an increased awareness of hemochromatosis is made.

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Congenital Anomalies of the Urinary Tract in Infants and Children

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CONGENITAL urinary tract anomalies are most often manifested by the cardinal symptomatic triad of pyuria, fever, and abdominal pain, either together or singly, which usually indicates the presence of inflammation due to infection. However, they may be overshadowed by the frequently accompanying symptoms of gastro-intestinal, neurologic, cardiovascular, or other systemic disturbances. This fact should be borne constantly in mind as, when investigations for non-urolgic disease are being carried out, the primary disease may be revealed as an unrecognized congenital obstructive uropathy with its resultant renal damage. Congenital malformations which are more commonly found in the urinary tract than elsewhere are the usual cause of urinary obstruction, which with its subsequent stasis is the most important predisposing factor in infection, especially that which is chronic. Various combinations of obstruction and infection constitute over 90 per cent of the major urologic problems in children.

Pyuria is the commonest symptom of urinary infection. In 580 cases of chronic pyuria investigated by Campbell,¹ one or more anomalies were found in 239 or 41.2 per cent of cases. Hepler and Scott,² in an evaluation of the significance of pyuria in the young, examined the urine of 400 male and 294 female children. Pus was found in the voided centrifuged specimens of 99 per cent of children and 36 per cent of voided uncentrifuged specimens; in 13 per cent of the centrifuged catheterized specimens and in 9 per cent of the uncentrifuged specimens. They showed that the degree of pyuria indicates neither the kind nor severity of the urologic disease, but point out that it is better to examine apparently unnecessarily an occasional child than to

neglect complete urologic investigation in many because the degree of pyuria seems minimal or within normal limits. As a rule, clouding of the urine by pus is readily recognized and becomes a source of alarm, but a mild pyuria may be overlooked for years by patient and physician alike. Therefore, the physician should never neglect a urinalysis even when systemic symptoms do not directly point to the urinary tract. If pyuria or other evidence of infection persists after four weeks of intensive medical therapy or is recurrent, a complete urologic examination should be performed. The necessity for early study in these cases cannot be overemphasized, for when failure to employ urologic aid results in serious urosurgical disease or loss of life, the attending physician must hold himself responsible for these fruits of medical neglect.

Fever commonly exists with chronic urinary infection and is usually low grade, but with the onset of acute obstruction or infection the temperature, ushered in by chills, may be extremely high and septic in type. Fever of unexplained origin in a child always calls for a careful urinalysis and urologic investigation.

Localized kidney pain is usually mild and is due to increased capsular tension, whereas severe renal pain radiates. The radiation of pain is governed chiefly by the tenth to twelfth dorsal and the first lumbar spinal cord segments. When marked renal pain produces a stimulation of the renal nerves, somatic reference or radiation of the pain may occur over the entire area supplied by these segments of the cord. Vagal extension to the medulla, gastro-intestinal or vasomotor disturbances may occur. An extension downward of painful stimuli from the affected cord center is commonly manifested by reflex vesical or urethral disturbances, chiefly urinary frequency or pain, and explains these

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symptoms in the absence of any demonstrable abnormal condition in the lower part of the urinary tract. The pain of acute urinary retention from obstruction is in reality an intense desire to void and may be localized to the viscus itself or to the suprapubic region, but is commonly referred to bladder neck or urethral meatus. At times vesical pain is referred to the abdomen as a general intraperitoneal discomfort.

The architectural and functional damage caused by urinary back pressure is the primary result of congenital anomalous obstruction and is equally as important as infection. The character and extent of the changes depend upon the location and type of obstruction and upon accompanying complicating factors. The nearer the obstruction approaches the ureteropelvic junction, the more acute and earlier in appearance are the symptoms of hydronephrosis and the more rapidly destructive is the process. Obstruction occurs most commonly along the ureter and is usually due to a stricture. This type of lesion along with aberrant vessels causes the majority of unilateral hydronephroses in children. Ureteral strictures are unilateral and single in two-thirds of the cases in which they appear, but may be bilateral and/or multiple. If bilateral, the fundamental anatomic change of obstruction, dilatation, is manifest in both kidneys and frequently causes an early death.

Infection occurs in practically all cases of bilateral obstructive uropathy, due either to supravescical or infravesical obstruction and may be anticipated in everyone. When the obstruction is infravesical, changes in the upper part of the urinary tract are always bilateral and may be unequal in degree. In the early stages the bladder acts as a protective buffer for the upper part of the urinary tract and empties itself in spite of the obstruction by compensation and the bladder becomes dilated. During this process, elevation of the intracystic pressure to or above the peristaltic expulsive force of the ureters causes decompensation of the uretero-vesical valves. This leads to uretero-vesical reflux which overcomes attempted ureteral compensation, manifested by exaggerated peristalsis, and causes rapid lateral and longitudinal dilatation of the ureters. Most important, this urinary back pressure causes the greatest damage in the kidneys.

In the absence of infection, parenchymal injury produced by compression and by interference with the vascular supply is the most serious

lesion in obstructive uropathy. The end point is a urinary system of widely patulous channels above the infravesical obstruction in which intravesical and intrapelvic pressures are identical except for postural changes. If these pressures are maintained at renal secretory level, anuria occurs. At lower pressures, renal function is seriously handicapped and varying degrees of azotemia are manifested. The principal congenital obstructions of the lower part of the urinary tract are bladder neck contracture, posterior urethral valves, hypertrophy of the verumontanum, urethral stricture, especially at the meatus, and neuromuscular vesical disease.

The accurate diagnosis of urinary tract disease requires a thorough urologic examination, for which special apparatus and technique are required. In general, these investigations include a special examination of the urine and blood, plain roentgenograms of the urinary tract, cystoscopy, ureteral catheterization, divided renal function tests and, in the majority of cases, retrograde pyelography. Excretory urography has gained a definite place in our diagnostic armamentarium, but due to difficulty in adequate preparation leaves much to be desired in a large proportion of cases. In those children in whom an abnormality is indicated by excretory urography, retrograde studies are almost invariably needed as confirmation. Cystography, using 5 per cent of an excretory contrast media, may be of marked diagnostic value and warrants more use than it commonly has had.

With these means of study a reasonably accurate preoperative diagnosis can be made in practically every case, so no patient should be blindly explored. If this is done, renal tumors may be cut into, their capsules broken, and any hope of cure lost. Equally as dangerous, the only functioning kidney may be removed. An early diagnosis favors surgical conservation rather than loss of the diseased organ. Urologic investigation in children should be entrusted to the trained urologist. In his hands the dangers of urologic instrumentation correctly performed in a patient adequately prepared are negligible and merit little concern. It has been statistically shown³ that in skilled hands children tolerate these investigations far better than adults do, and that reactions are fewer and less severe.

The following brief case reports are illustrative of several types of congenital anomalous obstructions causing the symptomatic triad:

Case Reports

CASE 1.—J. T., a 7-year-old white boy, had a history of intermittent fever, pyuria, abdominal discomfort, anorexia, and loss of weight for six to seven months. On urologic examination both kidneys were easily felt and the bladder was found to be distended and atonic. The blood nonprotein nitrogen was 40 mg. per 100 cc. and there were 15 to 16 pus cells per high power field. Intravenous urography visualized a large distended bladder, minimal hydronephrosis of the right kidney, kinking of the right ureter, and redundancy and slight dilatation of the left ureter. On cystoscopic examination there were found a median bar of the posterior vesical neck, an atonic bladder, and a deep post-trigonal depression. Transurethral resection of the posterior vesical neck was carried out. Convalescence was uneventful and on discharge, on his eleventh postoperative day, the blood nonprotein nitrogen was 30 mg. per cent, the urine contained 4 to 5 pus cells per high power field, and he had no further abdominal distress. His appetite was excellent. On mandelamine therapy the urine subsequently became normal. On one-year follow-up the child is in excellent health.

CASE 2.—A. L., a 12-year-old white boy, had a history of abdominal distention, indigestion, epigastric pain, intermittent fever, pyuria, and loss of weight for six months. Physical examination was urologically negative. Blood nonprotein nitrogen was normal, and there were 8 to 10 pus cells per high power field in the urine. Intravenous urography visualized an obstruction at the right uretero-vesical junction distal to the intramural ureter with dilatation of the ureter, pelvis, and calyces above the obstruction. On the left there was a slight obstruction at the same level with beginning ureterectasis of the lower one-third of the ureter. The abnormality was thought to be due to congenital ureteral strictures. Cystoscopy, however, visualized a median bar of the bladder neck which was resected transurethrally. The ureteral caliber was greater than was anticipated, accommodating No. 4 F catheters with ease. The ureters were then dilated to No. 6 F. Convalescence was uneventful except for renal pain on the right side for two days postoperatively, and the patient was sent home on his sixth postoperative day. Fourteen months later he remained asymptomatic. Unfortunately the parents would not allow follow-up x-ray examination of the upper part of the urinary tract because he was so well.

CASE 3.—J. A. L., a 3½-year-old white girl, had a history of recurrent pyuria, fever, and chills resistant to antibiotic and chemotherapy. Physical examination revealed no abnormality. Renal function was normal and the urine was loaded with pus cells. Cystoscopy visualized a large trigonal curtain causing bladder neck obstruction. Behind this were normal ureteral orifices, and pyelography visualized a normal upper urinary tract. Urine cultures from the bladder and kidneys showed a growth of *Bacillus coli*.

Suprapubic cystostomy was done for trigonal resection. It was then noted that there was a large cystic space beneath the bladder and the large redundant trigone. In the mid-line in front of the trigonal cur-

tain was a small opening into which a ureteral catheter could be inserted. The trigone was incised and a large multilocular space was entered, the posterior wall of which was adherent to the sacrum. It was felt that additional information was necessary before attempting further surgery, so the redundant trigone was resected and an artificial stoma made connecting the cavity with the bladder. Convalescence from this procedure was uneventful and later cystography visualized a large duct opening off the base of bladder, extending posteriorly, then up the right side of the abdomen, and ending in a large rectangular-shaped cavity beneath the diaphragm that was retentive.

The patient continued to have pyuria in spite of intensive antibiotic and chemotherapy. Therefore, a nephro-ureterectomy was performed excising an anomalous upper urinary tract on the right side and leaving only a small diverticulum attached to the bladder. Exploration showed the anomalous state to be due to a fused double kidney with complete ureteral reduplication, the ureters lying within the same sheath. Heminephrectomy was planned, but due to the anomalous arrangement of vessels which entered the kidney through the sacculated upper pole, this was technically impossible and a complete nephro-ureterectomy was done. Convalescence was uneventful and on discharge from the hospital July 16, 1949, her fourteenth postoperative day, urinalysis and urine cultures were negative. A subsequent urinalysis was normal.

CASE 4.—D. L. S., a 5-year-old white boy, was admitted to the hospital with a history of fever, abdominal pain, marked pyuria, and colon bacilluria. He was irrational. Physical examination disclosed marked renal and abdominal tenderness on the right side. The urine was loaded with pus cells. Renal function was normal. Excretory urography visualized a right hydronephrosis and hydro-ureter due to a ureterocoele. This was confirmed by cystoscopy. A large ureterocoele was excised suprapubically. Convalescence was uneventful and the boy was sent home on his thirteenth postoperative day. Subsequently, the right ureter was dilated three times with an increase in function of the kidney and less hydronephrosis. There were recurrent chills and fever for seventeen months, but in the past six months he has been asymptomatic and urinalysis and culture are normal. However, nephro-ureterectomy may be necessary in the future.

CASE 5.—C. P., a 5½-year-old white girl, had a history of recurrent pyuria, fever, and urinary frequency resistant to medical therapy for nine months. Physical examination showed nothing abnormal except a slight renal tenderness on the left side. Renal function was normal and urinalysis showed a colon bacilluria and many pus cells per high power field. Excretory urography visualized a normal upper urinary tract except that on the left only the upper component of a fused double kidney was functioning. Retrograde pyelography confirmed the diagnosis of a non-functioning hydronephrosis of the lower component of a fused double kidney due to a ureteral stricture at the ureterovesical junction. Repeated ureteral dilatations resulted in a slight reduction in size of hydronephrosis and slight return of function, but there was a recurrent staphylococ-

cic pyuria. Therefore, heminephrectomy was done. Convalescence was uneventful and the child was discharged on her ninth postoperative day. Six months later there has been no recurrence of symptoms.

CASE 6.—M. L., a 6-day-old white girl, was admitted to the hospital with a history of pyuria, fever, and azotemia. Abdominal examination revealed bilateral large multicystic masses in the upper part of the abdomen, the right side being the more tender. Microscopic examination showed that the urine was loaded with pus cells and the blood nonprotein nitrogen was 85 mg. per 100 cc. of blood. Cystoscopy visualized a normal lower urinary tract and on pyelography a large hydronephrosis was found on the left side which was due to a stricture at the uretero-pelvic junction. On the right side there was an impassable intramural ureteral stricture. Bilateral renal exposure revealed a completely polycystic right kidney. The cysts were incised and pyelostomy drainage established. On the left side there was a large hydronephrosis of a kidney, the remaining parenchyma of which was studded with minute cysts. Pyelostomy drainage was established. The baby improved temporarily under drainage and antibiotic therapy and became afebrile, but the remaining functioning renal tissue was too slight and she died of uremia two months later.

Summary

1. The symptomatic triad of pyuria, fever, and abdominal pain usually indicates congenital urinary tract anomalies. They may be accompanied by overshadowing systemic symptoms.

2. The three common symptoms are analyzed.

3. The primary result of congenital obstruction is the architectural and functional damage caused by urinary back pressure. This is discussed in relationship to the location of the obstruction.

4. Methods of urologic examination which establish an accurate diagnosis are discussed. No patient should be blindly explored.

5. Illustrative cases are presented.

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CHRONIC ILLNESS PROGRAM IN CONNECTICUT

Connecticut has launched one of the first state-wide study-planning-action programs to meet the problem of chronic illness, "to enable everyone in Connecticut to enjoy a healthy and productive maturity by controlling chronic disease and by relieving other physical, mental and social problems of adult life."

The Connecticut General Assembly of 1939, through the efforts of the Connecticut State Medical Society, created "The Commission on the Care of People Afflicted with Physical or Mental Disabilities."

Dr. Creighton Barker, a member of the present national Commission on Chronic Illness and executive secretary of the Connecticut State Medical Society, was the chairman of the commission and its report became known as the "Barker Commission Report."

As a result of the commission's study and report, certain recommendations were made to the Connecticut General Assembly of 1941. The state medical society supported these recommendations and, although the measures were not passed at that time, the society continued to advocate a program for the chronically ill.

These activities resulted in the passage of legislation by the General Assembly of 1945 creating a permanent Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm. Dr. A. Nowell Creadick, now the full-time medical director of the commission, was its first chairman.

Recognizing the need for study, the state commission

has begun a pilot study in rehabilitation at Rocky Hill Veterans Home and Hospital where 70 beds of the existing veterans hospital were set aside for the chronically ill. These and the 350-bed veterans hospital are operated jointly by the Veterans Commission and the Commission on the Chronically Ill.—Chronic Illness News Letter, September, 1950.

ALL-INCLUSIVE CHEST SERVICE

The care, the study, and the teaching of tuberculous disease today should be the responsibility of the broadly trained medical internist-investigator in close association with the highly proficient, experienced chest surgeon as part of the larger problem of the better understanding and control of all cardiopulmonary diseases involving the chest. Such an all-inclusive chest service should be an integral part of every large general hospital and medical teaching center in the best interests of patients, physicians, undergraduate medical students, and resident staff. This means medical center segregation in the future rather than sanatorium isolation as in the past, with the tuberculous patient receiving equal acceptance and complete attention, including prompt recognition and specific treatment of his nontuberculous complications which oftentimes threaten his existence more seriously than does the tuberculosis itself.—CHARLES A. DOAN, M.D., *Ohio Public Health*, May, 1950.

Modern Treatment of Actinomycosis

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ACTINOMYCOSIS is a rather infrequent endemic disease. Cope stated that wherever there is a microscope and a laboratory this fungus has been found to be a cause of disease. It is the commonest of the systemic fungus infections and occurs in both the one anaerobic and numerous aerobic forms. The aerobic form is so rarely a cause of progressive disease that authorities recommend that only the disease caused by the anaerobic *Actinomyces bovis* be called actinomycosis and any other of the family take name from the genus *Nocardia*, i.e., nocardiosis. Zieser's latest edition of *Textbook in Bacteriology* (1948) states that progressive disease of the aerobic *Nocardia* cannot be produced.

Cope, in 1930, collected 1330 cases in the literature and found that 56 per cent occurred in the maxillofacial area, 23 per cent in the abdomen, and the remainder in the chest. The anaerobic *Actinomyces bovis* does not occur on vegetable matter such as hay and grass, but is a normal inhabitant of the oropharyngeal cavity. It attacks only as a secondary invader, as in an ulcerated area of the gum, a diseased tonsil, peptic ulcer, or appendicitis.

While it may take more tests on rare occasions, for practical value the organism *Actinomyces bovis* can be determined as an anaerobic with gram-positive granules and containing branching elements. It grows best in a beef infusion broth. There is also a marked clubbing formation at the periphery giving it the nickname of the ray fungus. The organism frequently is most difficult to isolate. Bagenstross, in a study of 35 autopsies at the Mayo Clinic, could demonstrate *Actinomyces bovis* in 21, doubtful in 3, and not at all in 11.

The disease occurs in adolescence and middle age, being rare before 10 and after 40 years of

age. The prognosis is grave, particularly in abdominal actinomycosis. So discouraging was the picture before the advent of sulfone therapy and antibiotics that Shearburn, in 1943, reporting two cases of primary involvement of the stomach, said that his patient was the only one reported in the literature who was alive after one year.

Good, in 1931, found that 62 cases from the Mayo Clinic had an adequate follow-up; of 50 cases, 29 were dead, 7 showed no improvement, 6 had some degree of improvement, and 8 were apparently arrested.

A similar discouraging outlook was given by Wangenstein in 1936. Of 5 cases with previous appendectomy, 4 were dead and the fifth showed no improvement.

With sulfa therapy the prognosis improved, and Nichols and Herrell, in 1947, found a definite improvement with the use of penicillin. Of 8 abdominal cases treated with penicillin and sulfonamides, 6 recovered, while of 16 cases without this therapy, only 3 recovered.

Campbell and Bradford, in 1948, reported 6 cases of abdominal actinomycosis with recovery and stated that one of these was the second reported in the literature in which a patient with actinomycosis of the liver had survived.

The Vanderbilt University group, in 1947, pointed out the relative effectiveness in vitro of streptomycin in actinomycosis. Wangenstein and Lyons were early in insisting that the majority of patients with abdominal actinomycosis require drainage of the abscess or extirpation of the granuloma in order to effect a cure. In 1948 Nichols and Herrell recommended the combined use of penicillin and sulfonamides or streptomycin in this treacherous infection.

In our case, when penicillin and sulfonamides with incision and drainage did not produce a cure, and two series of streptomycin alone did not stop the slow definite progress of the disease, we elected to use the radical surgery recom-

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mended by Wangensteen with streptomycin and penicillin preoperatively and postoperatively—the streptomycin to be most effective against the fungus; the penicillin to aid in this and also to control the associated bacteria present.

Case Report

A. J. S., a 33-year-old white man, native born, was admitted to the hospital Jan. 1, 1947. During his three stays in the hospital he was under the care of the medical service of Dr. Robert Garver and the surgical service of the author. He stated that he had been well until Thanksgiving Day, 1946, when he noticed a swelling of the left upper quadrant of his abdomen. The pain had never been severe, but was more of a dull constant aching character. He had noted no fever or chills. In the two days prior to admission a thin foul muddy discharge had drained spontaneously. On review of the various systems, the patient admitted an occasional dry morning cough which he attributed to cigarette excess and a mild indigestion.

Although the patient had had some mild indigestion, he had no digestive disturbances in the nine months prior to admission, which he attributed to observance of a gallbladder diet.

Examination showed a robust stocky young white man in no great pain. There was a large firm flattened mass 10 cm. in diameter in the upper left quadrant of the abdomen. This was not tender and extended superficially from the epigastrium to 2 cm. above the level of the crest of the ileum. There was a small draining sinus near the center of this mass.

Laboratory tests showed repeated normal urinalyses. There was no anemia or leukocytosis and the stained smear showed a normal differential. The blood Kahn test was negative.

The patient was placed on sulfadiazine gr. xv and penicillin 100,000 units every three hours, and on his fifth day after admission a crucial incision was made in the large abscess to gain adequate drainage; the disc-shaped cavity measured 4 cm. in depth and 8 cm. in diameter. There was no evidence of extension from the pleural or peritoneal cavity. The fluid was thin, yellow, and turbid in character. Cultures and biopsies of the abscess wall were taken.

A fungus infection was suspected from the day of admission, but preoperative, operative, and postoperative cultures for fungi and bacteria remained negative for two weeks. The biopsy was reported as "granulation tissue, an abscess of abdominal wall."

The wound was packed, opened, and the pack was withdrawn in an endeavor to permit it to obliterate with granulations. During his hospitalization the patient received a total of 230 grams of sulfadiazine and 4,500,000 units of penicillin.

In the next nine months a chronic sinus persisted with slight watery drainage which would at times close for several days to a week and then reopen. There was considerable but varying induration of this area. Dozens of cultures and smears were taken, and finally the laboratory isolated the *Actinomyces bovis* fungus and this was later confirmed with another smear.

In June, 1947, the patient took a week's course of 1.25 milligrams of streptomycin four times daily as an out-

patient. He was readmitted to the hospital June 14, 1947, and remained until June 21, 1947, during which time he received 125 milligrams of streptomycin every three hours for a total of 5.5 grams.

The sinus and drainage persisted, although the patient was able to carry on his usual work.

On his third admission, from June 1, 1948, until June 29, 1948, the patient received preoperatively a total of 8.2 grams of streptomycin and 1,100,000 units of penicillin. These drugs were continued postoperatively, making a total of 23.2 grams of streptomycin and 6,900,000 units of penicillin received during this admission.

In the two years previous to the patient's operation he had had x-rays of the stomach, duodenum, and gallbladder which had been reported normal. Roentgenograms of the chest were also normal. A barium enema had likewise been normal. Sputum examinations, blood Kahn tests, blood counts, and blood chemistry were all within normal limits.

The patient had a septic temperature preoperatively running between 99 and 103° F. Nevertheless, on his eighth day after admission an exploration was done. At operation on June 8, 1949, wide transverse elliptical incisions were made extending beyond the indurated area of the left hypochondrium and epigastrium and from the costal arch to beyond the umbilicus. The large indurated mass involved the left rectus muscle so that the entire muscle in this area was removed. Since the peritoneum was likewise involved, the peritoneal cavity was opened away from the lesion and a large indurated mass was found involving over half of the fundus and body of the stomach extending into the gastrocolic omentum to the transverse colon and in the gastrohepatic ligament to the liver; an abscess containing frank yellow pus was present in the latter. The gallbladder, duodenum, and remainder of the small intestine were normal. The mass and abscess extended into the liver and there was bile drainage after the abscess wall was removed.

A radical removal of all the diseased tissue was accomplished including a large segment of the abdominal wall, the distal two-thirds of the stomach, a large portion of the gastrocolic ligament and serosa of the transverse colon, the gastrohepatic ligament and undersurface of the liver; an anterior gastrojejunostomy (Polya) and jejunostomy were done. A plastic repair was then done on the abdominal wall. The operation was performed under pentothal, ether, and curare anesthesia over a four-hour period; 3500 cc. of blood was transfused at this time.

The pathologic report showed 390 grams of abdominal wall measuring 20 x 11 x 3 cm. with fistulous tract and sinus opening, also the distal end of the stomach (about two-thirds) including the pyloric ring, 8 cm. on the lesser and 22 cm. along the greater curvature, and a small perforation of a deep ulcer near the greater curvature. There was marked thickening of the wall and general edema with diffuse fibrosis of the muscularis and submucous coats. Microscopic examination showed actinomycosis of the abdominal wall, also ulceration and perforation of the stomach.

On Sept. 26, 1949, the patient was well, completely healed, and working.

Summary

1. A brief review is given of the growth habits, appearance, and drug sensitivity of *Actinomyces bovis*.

2. A case of advanced actinomycosis involving the abdominal wall, the stomach, liver gastrocolic and gastrohepatic omentum is reported with a cure combining radical surgical principles with streptomycin and penicillin given preoperatively and postoperatively.

3. There is a reminder that the relatively in-

nocent aerobic member of this family occurs in grass and vegetables and the serious anaerobic *Actinomyces bovis* occurs as a normal mouth inhabitant and invades injured and ulcerated areas.

4. In the presence of a sinus formation and stiff woody swelling, actinomycosis should always be considered.

5. Even in autopsy material the organism may be identified in only 60 per cent of the cases.

6. Further time is needed to evaluate and compare therapeutic agents.

LUNG CANCER LINKED TO PROLONGED TOBACCO SMOKING

A significant relationship between prolonged tobacco smoking and development of cancer of the lung is shown by two reports published in the May 27 *Journal of the American Medical Association*.

Excessive and prolonged use of tobacco, especially cigarettes, seems to be an important factor in causing cancer which originates in the lungs, Ernest L. Wynder, B.A., and Dr. Evarts A. Graham of Washington University School of Medicine and Barnes Hospital, St. Louis, conclude.

Among 605 men with lung cancer, 96.5 per cent were moderately heavy to chain smokers for many years, compared with 73.7 per cent among the 780 men in the general hospital population without cancer, the St. Louis doctors point out. Among the cancer group, 51.2 per cent were excessive or chain smokers compared to 19.1 per cent in the general hospital group.

"In general, it appears that the less a person smokes the less are the chances of cancer of the lung developing and the more heavily a person smokes the greater are his chances of becoming affected with this disease," they say.

Smokers were classified on the basis of number of cigarettes smoked per day for 20 years or more. Pipe and cigar smokers were included by counting one cigar as five cigarettes and one pipeful as two and a half cigarettes. Light smokers were classified as smoking one to nine cigarettes, moderately heavy smokers 10 to 15, heavy smokers from 16 to 20, excessive smokers 21 to 34, and chain smokers 35 or more.

There may be a lag period of 10 years or more between the cessation of smoking tobacco and the occurrence of clinical symptoms of cancer, however, the St. Louis doctors found. Among the patients with cancer who had a history of smoking, 96.1 per cent had smoked for over 20 years.

The occurrence of carcinoma of the lung in a male non-smoker or minimal smoker is a rare phenomenon (2.0 per cent), according to the study.

Tobacco seems to play a similar but somewhat less evident role in causing cancer in women, the doctors

found. The incidence of lung cancer is less in women than in men today. This is believed to be due in part to the fact that few women have smoked for more than 20 years.

There is rather general agreement that the incidence of bronchogenic carcinoma has increased greatly in the last half century, the doctors point out. The enormous increase in the sale of cigarettes in this country approximately parallels this increase of bronchiogenic carcinoma.

Among male patients with cancer of the lungs, 94.1 per cent were found to be cigarette smokers, 4.0 per cent pipe smokers, and 3.5 per cent cigar smokers. This prevalence of cigarette smoking is greater than among the general hospital population of the same age group. The greater practice of inhalation among cigarette smokers is believed to explain the increased incidence of the disease.

Data obtained from 1650 patients admitted routinely to the Roswell Park Memorial Institute, Buffalo, N. Y., indicate that in a hospital population cancer of the lung occurs more than twice as frequently among those who have smoked cigarettes for 25 years than among other smokers or non-smokers of comparable age, according to another study published in the same issue of the *Journal of the AMA*.

"Pipe smokers apparently experience an almost equal increase in the incidence of lip cancer, compared with other smokers or non-smokers," says Drs. Morton L. Levin, Hyman Goldstein, and Paul R. Gerhardt of the Bureau of Cancer Control, New York State Department of Health, Albany.

"The data suggest, although they do not establish, a causal relation between cigarette and pipe smoking and cancer of the lung and lip. Cancer is now generally considered a disease attributable to multiple causative factors. Among these are 'irritants.'

"An irritant which is non-carcinogenic alone may nevertheless increase the percentage of tumors produced when its action is combined with that of a carcinogen. Thus, some experimental basis exists for explaining the apparent effect of cigarette and pipe smoking, although the true nature of the association with lung and lip cancer remains to be determined."

Thrombophlebitic Edema of the Legs and Its Control by a Flexible Laced Stocking

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EDEMA of the legs often follows thrombophlebitis and it may persist for a long time. This edema increases during the day when the patient is on his feet and tends to decrease during the night while recumbent. In the early stages the edema may be due mainly to vasospastic phenomena. Actual venous occlusion probably plays a minor role in many instances. Ligation of the femoral vein just distal to the profunda tributary rarely causes any edema. In patients who have not had the femoral vein ligated, the vein may later recanalize, but when it does, the channel that forms may have no functioning valves. The valve leaflets may become distorted or obliterated by scar tissue, and the valves of the communicating veins may be involved.

In the erect position the deep veins normally are emptied when the muscles of the leg contract against the resistance offered by the surrounding envelope of deep fascia. The blood is squeezed upward by a milking process and is prevented from returning downward by the valves. The valves of the communicating veins prevent this muscular contraction from pushing the blood out into the superficial veins. When the valves have become distorted or destroyed, the deep veins cannot be adequately emptied by this mechanism of muscular contraction. When the muscles relax, deficient valves allow blood to run down from above and allow the hydrostatic pressure of the long column of blood, extending up to the right portion of the heart, to become effective in the leg. In addition, heavy lifting or straining causes a further increase in deep venous pressure.

A similar situation prevails in the superficial veins when the valves between the deep veins and the superficial veins do not function properly. Venous pressure increases in the erect position. The increased pressure present in the small

venules and capillaries causes increased filtration of fluid from the capillaries, resulting in edema. The stasis may cause sufficient anoxia to damage the capillary walls so that there is an outflow of protein and cells into the intercellular spaces. This protein-rich fluid acts as a stimulus to fibroblastic proliferation. The cellular elements probably contribute to the pigmentation. Reflex neurovascular disturbances originating in the damaged veins may also be factors in the altered mechanics of the local venous circulation. Eventually there develops the typical swollen and in-



durated leg, which later shows dense fibrous plaques in its lower portion and hyperpigmentation of the skin. Characteristic ulceration may appear. These ulcers may be of the "varicose" or "phlebitic" type, or one ulcer may exhibit both features. One suspects that a chronic low-grade phlebitic process is present in the veins in these cases, whether the condition appears in a patient following a typical attack of thrombophlebitis or in one with varicose veins who gives no definite history of an antecedent attack of phlebitis.

After seeing a large number of patients with chronic ulcers, I became impressed with one feature of the process, often very striking. The edema, fibrosis, and pigmentation stop at the top of the shoe. The skin and soft tissues of the feet often look surprisingly soft, pliable, and free of edema and pigmentation as contrasted to the leg above. The good condition of the foot appears to be due to the constant pressure of the shoe and the alternating high and low pressure which must accompany walking. This is analogous to intermittent massage.

The effect of pressure on the velocity of venous flow has been studied by Stanton, Freis, and Wilkins.* Constant pressure (made by an inflatable garment) of 20 to 35 mm.Hg. speeded the velocity of flow in the veins of the calf by 22 to 170 per cent. It has also been well demonstrated that when the outside pressure on the soft tissues of the leg is increased, the edema may diminish and a good deal of the inflammatory reaction will subside. This accounts for the efficacy of the gelatin boot in the treatment of varicose ulcers. Following an attack of phlebitis, it becomes necessary to make constant firm pressure in order to control the edema and to prevent the characteristic secondary changes.

The ordinary cotton elastic bandage is unsatisfactory. It is difficult for most patients to apply it properly, and since it tends to wrinkle and loosen in a few hours, it must be reapplied several times daily to be of any use. An elastic bandage made of cotton and rubber gives better compression of the leg, but it is also difficult to apply and must be several layers thick to be of any value; it also tends to wrinkle. The elastic stocking makes a more effective support, especially if it is well fitted and if the leg is not unduly deformed. The heavy-weight elastic stock-

ing and the lighter Lastex and similar types of stockings are quite useful, but have their limitations. A good example of this was seen in a physician, 52 years of age. He had an episode of pulmonary embolism three weeks after a prostatectomy, with development of frank thrombophlebitis in the left femoral vein two weeks later. The vein was ligated just below the saphenous vein. The preoperative edema decreased while he was in bed. He was allowed to be out of bed wearing a Lastex-type stocking. Follow-up four weeks later showed edema of the ankle just above the shoe-top despite the stocking. He was advised to wrap an elastic bandage over the stocking to maintain additional pressure. The edema subsided. A laced non-elastic stocking was then advised.

In many patients the stockings may become loose and ineffectual as the edema subsides or when the rubber stretches. At a result, the stocking may become inefficient and almost useless in a few weeks. These considerations have prompted an attempt to utilize some more efficient support.

An important point in this connection is the factor of elasticity: how much elasticity is required? The major propulsive force for blood in the lower extremities is the contraction of the muscles against the rigid overlying fascial envelope. The deep fascia is flexible but not elastic; it allows the pressure of muscular contraction to exercise its propulsive effect over a considerable length of deep veins. Since little elasticity is present in this fascia, little elasticity should be required in a compression dressing which works in a similar manner.

By placing firm compression over the surface of the entire leg, the superficial veins become subject to the same rhythmic muscular compression that acts on the deep veins. This compression dressing needs to be flexible and to fit evenly, but it does not necessarily need to be elastic. The stocking is made of heavy, only slightly elastic woven material, accurately cut to fit the leg and stitched up the back from heel to knee. The patient is instructed to put on and lace the stocking firmly each morning on arising. As the edema subsides over a period of days or weeks, the slack is taken up by the laces. When this no longer suffices, the stocking maker is requested to open the seam at the back of the stocking and to trim it to proper size. This stocking has proved to be quite useful in the management of some refractory cases of phlebitic edema.

* STANTON, J. R., FREIS, E. D., and WILKINS, R. W.: Acceleration of the Velocity of Venous Flow in the Deep Veins of the Lower Extremity of Man by Local Compression, *Bull. Am. Coll. Surgeons*, 34:41, January, 1949.

Summary

1. Firm compression of the leg helps to reduce phlebitic edema.
2. Ordinary elastic stockings and bandages are not altogether satisfactory.
3. A flexible non-elastic or only slightly elastic stocking has certain advantages.

WHAT OF IT?

A certain gentleman in a great dither of indignation because of a scurrilous article about him printed in the local paper went to a friend for advice on what to do.

The friend heard the matter, and then said "Do nothing." And gave the following reasons:

In the first place, he said, of all the people who opened the newspaper, only one-half of them saw the offending article. Of those who saw, only one-half bothered to read it. Of those who read it, only one-half understood what it was all about. Half of those who understood the article knew the gentleman himself too well to believe it. As for the other half who accepted the article as truth, they represented the sum total of damage done. And how long would they remember the incident? So do nothing!

This is excellent counsel to supersensitive people. They should have in one corner of the mind a pigeon hole marked "What of it?" and into that compartment file and forget the antagonisms that cannot be avoided.

Exchange.

GRADUATE SCHOOL ALUMNI PLAN TO ORGANIZE

A movement has been launched at the University of Pennsylvania to organize alumni of the Graduate School of Medicine as a new division of the General Alumni Society of the university.

The new unit, as presently outlined, would be separate and distinct from the university's Medical Alumni Society, the majority of whose members are graduates of the University of Pennsylvania School of Medicine. It would be concerned solely with affairs of the Graduate School of Medicine, whose alumni may have obtained their M.D. degrees either at the University of Pennsylvania or some other medical institution.

At the present time, graduates of both the School of Medicine and the Graduate School of Medicine are commingled in membership of the Medical Alumni Society. The total membership is in excess of 9000, scattered all over the world. Of this total, approximately 25 per cent are Graduate School of Medicine alumni.

In response to numerous requests, Dr. William S. Parker, dean of the Graduate School, has appointed a faculty committee to supervise formation of the proposed new organization. The committee includes the

following well-known Philadelphia physicians: Drs. William Bates, Oscar V. Batson, Julius H. Comroe, Jr., and Joseph C. Yaskin.

Organized in 1919, the Graduate School of Medicine was the first comprehensive graduate medical school in this country established for the basic training of physicians in clinical specialties. With it were merged the old Medico-Chirurgical College and Hospital and the Philadelphia Polyclinic and College for Graduates. The school now conducts long-term courses in 20 medical and dental specialties. It has graduated more than 4000 medical specialists.

While the main teaching center of the university's Graduate School of Medicine today is the Graduate Hospital, located at 19th and Lombard Streets and dating from 1928, the Graduate School has access to the facilities of 30 hospitals, 12 laboratories, and 14 other institutions. Its faculty of 738 members is representative of many other medical institutions in the Philadelphia area.

THE G.P. AT THE CROSSROADS

The amount of money being spent on hospitals, specialists, eyes, and teeth obscures the most important problem of modern medicine—the status of general practice. General practice is at the crossroads. The general practitioner sees himself being elbowed out of the hospital, finds himself more isolated than ever before from his colleagues in specialist and consulting practice, is plagued with paper work, and sees little prospect of obtaining those pleasant conditions of work so alluringly offered to him by the propagandists for the National Health Service during the years before July, 1948.

In the absence of hard constructive thinking and action flowing from it there is a grave risk that general practice will deteriorate and cease to attract into its ranks a goodly proportion of men and women of first-class ability—the men and women who set the high standards for others to follow. It is infinitely harder to be an able general practitioner than to be an able specialist. Yet in the N.H.S. the bait is set to attract the latter and almost to repel the former. Modern medicine has put in the hands of the general practitioner a wide range of exact diagnostic techniques and an armory of powerful drugs. To be able to use these in the conditions of general practice calls for higher qualities and a greater resourcefulness than are required in any other branch of medicine. Yet peculiarly little is being done to face these problems squarely or to try to determine consciously the direction that general practice shall take. Standing at the crossroads, the general practitioner may by turning in one direction become little more than a medical orderly, or by turning in another direction may be tempted to become a half-fledged specialist. If he is to go forward to occupy the most responsible position in the practice of medicine fully equipped and with confidence in his high calling, he must pause and take stock of a situation which in the view of many shows signs of rapid deterioration.—Excerpts from an editorial in the *British Medical Journal*, March 25, 1950.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

PRESIDENT STILL INSISTS ON SOCIALIZED MEDICINE

At a dinner meeting closing the four-day conference, September 13, in Pittsburgh, of the National Tax Association, U. S. Senator Harry F. Byrd (Democrat of Virginia), speaker of the evening, said, "The Administration is irrevocably devoted to the socialistic state. The President and our leaders still insist upon socialized housing, socialized medicine, and socialized farming."

Additional evidence that the proponents of national socialization are not influenced by more immediate and pressing national problems to slow down their strictly political activities may be found in the following quoted from the September 18 issue of *Washington Report on the Medical Sciences*: "First issue (September 16) of Democratic National Committee's national 'clip sheet' quotes Senator James E. Murray (D., Mont.) as deploring the AMA's outlay for press, radio, and magazine advertising as waste of money that could be more usefully spent for medical education and research. The Montanan's co-sponsor on health insurance legislation, Representative Dingell, meantime was following a similar line in the House, charging that

\$20 million will be put into 'this unholy, un-American propaganda campaign'—AMA's own \$1,100,000 and an estimated \$19 million in so-called tie-in advertising."

This information about September's political activities of the proponents of socialized medicine should remind the friends of free enterprise, including the voluntary forms of sickness insurance, that they should be alert to every opportunity to influence voters in the November 7 general election.

That Mr. Oscar Ewing, chief lobbyist, is not idle was dramatically highlighted in August by Representative Buchanan (D., Pa.), chairman of a House committee to investigate lobbying, who reluctantly haled Mr. Ewing to appear for questioning. Congressman Brown (R. Ohio) definitely struck pay dirt when his adroit questioning forced Ewing to put on a bold front and to proclaim that it was "not only his right but his duty" to propagandize in favor of the Truman compulsory medical insurance program. In this mission Ewing admitted to having the assistance of 65 full-time publicity men, paid by the taxpayers.

The September 18 issue of *Washington Report on the Medical Sciences* also speaks of time-

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

ly war-related "belt-tightening" as it may affect health and medical interests:

"From here on out, the health professions and allied institutions should be prepared for all kinds of retrenchment in the interest of military strengthening and civilian preparedness. Already the Hill-Burton hospital construction program has been cut 50 per cent for the current fiscal year, from \$150 million to \$75 million. Within the next few weeks, several hundred medical Reservists are expected to get active duty orders and this depletion of the civilian doctor supply, combined with steadily increasing numbers of volunteers among younger practitioners who are vulnerable to the doctor-draft law, will give many hospitals something to think about. Public Health Service and other Federal grant-in-aid programs for medical research, fellowships, and public health control measures are certain to be cut back sharply with those projects which can be demonstrated to be most closely identified with defense efforts standing the best chance of approval."

THE PUBLIC HEALTH LAW RESEARCH PROJECT

Readers of the PENNSYLVANIA MEDICAL JOURNAL must by now be fully cognizant of the study being conducted by the Society and other interested organizations of the survey, Keystones of Public Health for Pennsylvania. That an article regarding it has appeared in the *American Bar Association Journal* is not so generally known.

The project, now nearing completion, after more than 16 months' intensive effort, is being carried out by several full-time graduate research fellows at the law schools of both the University of Pennsylvania and the University of Pittsburgh. This research is being conducted under the general supervision of the respective deans and is liberally supported by funds from the A. W. Mellon Educational and Charitable Trust.

The trustees of this fund have approved the expenditure of an amount of money far in excess of that needed for the survey itself in order to study one of the eight keystones, namely, "simplification, revision, and codification of the laws relating to public health." This support indicates a fine sense of values and a social responsibility that must certainly be widely approved by the medical profession.

The need for this research and its ultimate goal are succinctly described in the article reprinted on page 1135 of this issue. "Public health laws suffer not only from indifferent draftsmanship, to which so many state and local laws are heir, but also from the fact that science has moved rapidly in the past fifty years. Laws often include the vestigial remains of the obsolete science; they are geared to the medical knowledge of 1900 or 1920 rather than that of 1950. Codification is no mere problem of ironing out verbal and legal inconsistencies. To create a code that will most effectively serve the present and the future requires the closest kind of collaboration among legal, administrative, and scientific personnel."

Each person associated with the project at both universities must derive great satisfaction from the knowledge that he has contributed constructively toward sound public health practice.

In view of the present international situation, this contribution could be decisive in an all-out war. Maintenance of industrial capacity depends on sound public health practice. So does life itself in the unhappy event of contamination of water, soil, and food by biologic or radioactive agents.

The physician needs no indoctrination regarding the value of research in the medical field. The profession will recognize the value of this cooperative venture in legal research by two of our great universities. It is not too early to devise methods for translating its results into effective legislation which will benefit every citizen.

GEORGE S. KLUMP, M.D.

"THE PSYCHOSOMATIC DILEMMA"

Under the above-captioned intriguing title there appeared in the April, 1950 issue of the *American Journal of Psychiatry* a comment which deserves the attention of all serious-minded medical practitioners. The author signs the article with initials, but they constitute no secret to the readers of neuropsychiatric literature. They stand for the name of one of the leading thinkers in the field. It behooves us all to pay heed to what he says. After pointing out the accepted meaning of "soma" prior to the coining of the term "psychosomatic," he says: "Psychosomatic medicine is only taken as a glar-

ing example of loose talking and loose thinking. If the aim of science is to advance knowledge and understanding, we are doing little good by perpetuating misunderstanding." He ends this particular paragraph with this very significant statement: "Often at present we literally do not know what we are talking about." Indeed, he winds up the article with this same comment: "If we bother to think at all, we might as well see it through and really be clear as to just what we are talking about."

The writer of these lines has had misgivings all along about this situation ever since the term "psychosomatic" captured the imagination of the medical profession. In a way it merely replaced the old "wastebasket" term of neurosis. That psychogenic factors frequently play a part in disease is a very old concept well known to neurologists and psychiatrists for a long time. But, it was felt by them that the mechanism, the individual mechanism of the particular patient concerned, had to be worked out and brought to the surface, i.e., to the attention of the patient in a way that he could accept the situation and explanation as a logical sequence. This requires application and work at times entailing many hours of probing. This is a far cry from the readiness with which modern practitioners say glibly "psychosomatic" and they feel that this is the whole answer to the individual's problem. The attempt to lump together many cases under one title and reduce them to a statistical basis is a mistake, and apt to mislead the very practitioners of the art. The diagnosis of a psychogenic condition still remains an individual problem which requires painstaking application in the individual case. It cannot be reduced to a simple all-embracing formula.

MAX H. WEINBERG, M.D.

Does a fluoroscopic study of the esophagus, stomach, and duodenum followed by film observations of these parts, followed by a six and twenty-four film, constitute a satisfactory routine study?

Competent radiology can demonstrate approximately 90 per cent of gastro-intestinal organic lesions by an adequate study of the section of the alimentary tract harboring the lesion. A so-called G.I. series as described above should provide adequate information regarding the proximal four feet of the gastro-intestinal tract, namely, the esophagus, stomach, and duodenum, but provides little information regarding the remaining ten to sixteen feet of intestine. Is not the twenty-four hour film practically worthless?

A progress meal study of the small intestine is a time-consuming examination requiring interval film and fluoroscopic observations until all of the small intestinal coils have been thoroughly explored, yet this procedure is a necessity if non-obstructive small intestinal lesions (fortunately rare) are to be "ruled in" or "ruled out." Adequate colonic study requires a barium enema, not a twenty-four hour film. This writer raises the question whether the term "G.I. series" should not be discarded, unless by common agreement it includes adequate investigation of the small intestine and a barium enema. Should not the complete study of the gastro-intestinal tract be designated as upper gastro-intestinal tract, progress meal, and barium enema study, or the examination limited to the section of the tract under suspicion of harboring a lesion? The present rather common practice of requesting a G.I. series and the not uncommon limited procedure employed without progress meal and barium enema is unsound. Too many physicians accept such an examination as an adequate study of the *entire* gastro-intestinal tract.

J. STAUFFER LEHMAN, M.D.

THE ROUTINE G.I. SERIES . . . ?

The value of a radiologic examination in the diagnosis of gastro-intestinal tract lesions is so well established that it is part of the routine work-up of any patient suspected of having a lesion of the alimentary tract. As a consequence, the radiologist is frequently confronted with a request for a G.I. series and provided with little clinical information. This raises the question as to what constitutes an adequate "G.I. series." Or, is there an adequate routine "G.I. series"?

THE 1950 UNITED STATES PHARMACOPOEIAL CONVENTION

The regular decennial meeting of the United States Pharmacopoeial Convention was held in Washington, D. C., May 8-10. Quietly, earnestly, without ballyhoo or fanfare, 376 delegates from nearly 200 institutions and organizations met to elect the Committee on Revision, to which is entrusted the responsibility of preparing two

revisions of *The United States Pharmacopoeia* during the next ten years, and to lay down the general policies for making such revisions.

The *Pharmacopoeia* and its sister standard, *The National Formulary*, are labors of love generally unappreciated either by the public, whose interests are served primarily, or by physicians, who take for granted purity and uniform potency in the preparations they prescribe. Being books of law rather than manuals of therapeutics, these works admittedly make dull reading, and the average practitioner has little occasion to consult them. Yet, he has a stake in both which is incalculable, for under Federal law they insure the availability of reliable pharmaceuticals for his daily use. To the selection of drugs and preparations for inclusion in the *Pharmacopoeia* are brought the aggregate wisdom and experience of distinguished clinicians from every branch of the healing art. To the establishment of tests, standards, and pharmaceutical details are called eminent pharmacists, pharmacologists, chemists, physicists, and biometricians from all parts of the country. The work goes on continuously, with the most painstaking care, in the best traditions of all contributing professions, and largely without remuneration.

In these days it is a matter of no small interest and significance that the legal drug standards of the United States are established by an agency which has no connection whatever with any official legislative body. The Congress has delegated to the United States Pharmacopoeial Convention complete responsibility in its given field. Such

action reflected originally the highest order of confidence. To date, the constitutionality of this delegation of legislative authority has not even been challenged in the courts. A more impressive testimonial to quality and professional integrity could hardly be adduced.

The United States Pharmacopoeial Convention is a truly representative body. Every accredited school of medicine and of pharmacy, every state medical and pharmaceutical association, all major organizations of pharmaceutical manufacturers, all legitimately concerned divisions of the executive branch of the Federal government, the medical services of the armed forces, the United States Public Health Service, and other organizations dealing with drugs are entitled to equal representation. The following were delegates from the Pittsburgh area at the most recent meeting: Drs. George D. Beal and R. V. Rice, Mellon Institute; Drs. Wendell B. Gordon and Paul L. McLain, University of Pittsburgh School of Medicine; Dean Emeritus Julius A. Koch, Dean Edward C. Reif, and Dr. John H. Wurdack, University of Pittsburgh School of Pharmacy; and Dean Hugh C. Muldoon, Duquesne University School of Pharmacy. Dr. Beal, long prominent in Pharmacopoeial affairs, was chairman of the nominating committee and has been re-elected to the Committee on Revision. Dr. Koch received special honors as the oldest delegate present in point of service; he has been a member of the convention for 63 years.

PAUL L. McLAIN, M.D.

TO BE REMEMBERED ON ELECTION DAY

At a dinner meeting closing the four-day conference, September 13, in Pittsburgh of the National Tax Association, U. S. Senator Harry F. Byrd (D. Va.), speaker of the evening, said: "The Administration is irrevocably devoted to the socialistic state. The President and our leaders still insist upon socialized housing, socialized medicine, and socialized farming."

State Benjamin Rush Award Winners Announced

The Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania chose Leroy Mikels of Stroudsburg, Monroe County, as "the outstanding lay individual who contributed most to the advancement of public health and to the improvement of health conditions in his respective community" during the past year.

The Trexler Foundation of Allentown, Lehigh County, was selected "the outstanding lay organization of Pennsylvania which did most to advance public health and to improve health conditions in the area it serves" during the past year.

Lehigh and Monroe County Medical Societies were among the 22 component societies which submitted 34 nominations for the 1950 Benjamin Rush Award.

Previous to the announcement of the final winners by the Board of Trustees, all societies held suitable public presentations of medallions to their respective nominees.

Monroe County's public relations committee arranged to hold its public presentation to Mr. Mikels on July 25 at a Lions Club of Stroudsburg dinner held at the Bartonsville Hotel. This event was attended by 75 Lions and guests. Among the invited guests were: Paul H. Shiffer, M.D., society president, and Evan C. Reese, M.D., public relations chairman. Station WVPO, Stroudsburg, tape-recorded the presentation to Mr. Mikels, and press reporters and photographers were present.

Lehigh County Medical Society held its public presentation on July 25 at the Lehigh Valley Shrine Club, Allentown. More than 60 community leaders of health and welfare organizations attended a special luncheon at which Robert L. Schaeffer, M.D., public relations chairman for the society, presented the medallion to Joseph P. Young, acting chairman of The Trexler Foundation. Among those present and speaking briefly were: Judge Ethan A. Gearhart, Drs. Martin S. Kleckner, society president, Willard C. Masonheimer, Benjamin Rush Award committee chairman, and Charles K. Rose, Jr., president-elect and press-radio chairman. The press was well represented, and Station WSAW,

Allentown, tape-recorded the proceedings for broadcast at a later hour.

Mr. Mikels' contributions of time, effort, money, and skill in organization and administrative work for public health have been fittingly crowned by this latest honor. He personally has financed, and guided through the depression years of the thirties, Monroe County's first and only bedside nursing service. During the past year, the Red Cross Public Health Nursing Service, organized and financially helped by Mr. Mikels, made 18,000 visits to Monroe County families. He organized the voluntary public Blood Donor Program in 1949 which provides free blood and plasma to Monroe County residents. Mr. Mikels was chairman of the American Red Cross Chapter in the Poconos from 1929 through 1947.

The Trexler Foundation, established in 1934, is a privately endowed organization which yearly allocates approximately \$250,000 "for the support of community health organizations and programs, for recreational facilities that support health, and for youth agencies that teach and encourage healthful living and good citizenship" within Allentown and Lehigh County.

Health agencies and organizations benefiting from the Foundation's invested funds during the past year include three hospitals, Mary Mosser Trexler Nursing Service, Red Cross, Blind Association, Crippled Children's Society, Tuberculosis and Health Society, Family Welfare Organization, Good Shepherd Home, Salvation Army, Children's Aid Society, Wiley Home for Orphaned Children, Sacred Heart Home and Trade School. Boy and Girl Scouts were supported, as were boys' and girls' clubs, the Y.M.C.A., Y.W.C.A., and Jewish Community Center.

Mr. Mikels and The Trexler Foundation were honored at Philadelphia when they were presented with the State Benjamin Rush Award at the Installation Meeting of the One Hundredth Annual Session on Oct. 17, 1950.

The following county medical societies participated in this year's Benjamin Rush Award project:

LAY INDIVIDUAL AWARD

<i>County</i>	<i>Nomination</i>
Allegheny	Mr. Adolph Schmidt
Butler	Mr. Elias Ritts
Centre	Mrs. Balser Weber
Clinton	Mr. Earl N. Harnish
Dauphin	Mr. Frank Robbins, Jr.
Erie	Mr. C. P. Grunden
Indiana	Mr. Edward H. Koontz
Lehigh	Mr. Edwin G. Flohr
Lycoming	Mrs. Belle C. Parks
Mifflin	Mrs. Dorothy C. Bernstein
Monroe	Mr. Leroy Mikels
Montour	Miss Dorothy Bonawicz
Philadelphia	Mr. Philip T. Sharples
Schuylkill	Mr. Joseph S. McDermott
Tioga	Mr. John Decker
Warren	Mr. Homer M. Mohr
Westmoreland	Mr. Roy C. McKenna

LAY ORGANIZATION AWARD

Adams	C. H. Musselman Foundation
Allegheny	Kiwanis Club of Pittsburgh
Armstrong	VF—Post No. 863

DANGEROUS DRUG ACT

Act 407 of the 1935 Session of the Pennsylvania Legislature is the Dangerous Drug Act.

Section 2 reads as follows:

"No hypnotic drug or analgesic or body-weight reduction drug, as defined herein, shall be sold at retail or dispensed to any person except upon the written prescription of a duly licensed physician, dentist, or veterinarian."

The signing of the prescription should be done by the physician himself.

"Regulation No. 1 promulgated under the Dangerous Drug Act requires a new prescription for each refill in excess of the number of refills specifically authorized by the original prescription."

The State Department of Justice has released an opinion using the following:

"... before a pharmacist may lawfully sell or dispense any analgesic, hypnotic, or body-weight reduction drug, ... whether it be by original prescription or by renewal, he must be in actual possession of a written prescription personally prepared and signed by a duly licensed physician, dentist, or veterinarian. Such prescription may be written by an assistant provided that it is verified by the signature of the practitioner."

<i>County</i>	<i>Nomination</i>
Bradford	Sayre BPW Club
Butler	Butler Rotary Club
Centre	State College Lions Club
Clinton	Lock Haven Kiwanis Club
Dauphin	Tri-County Crippled Children's Association
Erie	Erie Chapter—Alcoholics Anonymous
Fayette	Fairchance Firemen Ambulance Corps
Indiana	Lodge No. 931—BPOE
Lancaster	Junior League of Lancaster
Lehigh	The Trexler Foundation
Lycoming	Church Surgical Dressing League
Monroe	Stroudsburg Lions Club
Philadelphia	Philadelphia Society for Crippled Children & Adults
Schuylkill	Danato Post No. 792

WOMEN DOCTORS ELIGIBLE FOR COMMISSIONS

Appointment and concurrent assignment to active duty as reserve officers of women physicians, dentists, and allied specialists, has been authorized by the Department of the Army.

This marks the first time that authorization has been given for women to be commissioned in the Medical, Dental, Veterinary, and Medical Service Corps Reserves. They will be brought on duty under regulations currently providing for the commissioning of male officers in these Corps. Some women did serve in the Army as physicians and technicians during World War II, but their commissions have expired.

As reserve officers on active duty, these women will be given opportunities for clinical practice and advancement which are now available to male officers in comparable grades. Appointments will be in grades from first lieutenant to colonel, depending upon age, experience, and professional qualifications. The pay, allowances, dependency and retirement benefits which accrue to male officers will apply to the women medical reservists. Women physicians and dentists will also draw the \$100 a month professional pay allowed above the base pay of their commissioned rank. They will be eligible for service in every type of military medical facility, with the exception of forward medical installations in combat zones.

Major General R. W. Bliss, Surgeon General of the Army, said his office had received numerous letters during the past year from women physicians desiring military service.



OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D.,

Secretary-Treasurer



Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

AMA PRESIDENT-ELECT

John W. Cline, M.D., of San Francisco, assistant clinical professor of surgery at Stanford University Medical School, and a very active member of the AMA Campaign Coordinating Committee, is the new president-elect of the AMA.

Dr. Cline, who has had a notable career in medicine since his graduation from Harvard University in 1925, delivered a powerful acceptance speech before the House of Delegates after he was notified of his election.

"We are fighting for the freedom and the medical welfare of the people of our country," he said. "Our cause is estimable. Our position is strong.

"Our major dereliction has been the failure to develop to its full potential the aggregate strength of the individual members of the profession. I do not refer to dissident individuals or rump organizations of left wing orientation. These are numerically and intellectually insignificant and do not merit our attention.

"Most of our state associations and county societies have responded well. A considerable majority of our members have provided splendid support but far too many have not. This condition arises, not from a difference of principle but from failure to understand the problem.

"The active and vigorous participation of this group is essential and must be obtained at the local level."—*The Dauphin Medical Academician.*

ANSWER CURRENT QUESTIONNAIRES PROMPTLY

Officers and committee members of your state medical society regret the necessity for sending questionnaires to every doctor of medicine in Pennsylvania, society and non-society members alike. Each may receive more than one questionnaire before the end of 1950. They are essential to the physical welfare of civilians and soldiers, all of whom may be suddenly exposed to injury or death during war-related emergencies.

Each physician may be needed; therefore, his whereabouts, his experience and availability must be known to those who plan in advance to meet disaster, wherever or in whatever form it may occur.

Please complete and return questionnaires promptly.

THE 1950 UNITED STATES PHARMACOPOEIAL CONVENTION

"It was my privilege to represent The Medical Society of the State of Pennsylvania at the decennial meeting of the United States Pharmacopoeial Convention which was held at the Statler Hotel, Washington, D. C., on Tuesday and Wednesday, May 9 and 10."—HUGH McCauley Miller, M.D., Philadelphia.

Approximately four hundred delegates, representing two hundred institutions, constituted the 1950 U.S.P. Convention. It will be recalled that the convention is composed of delegates from recognized medical and pharmaceutical colleges and state associations and a number of related national bodies as well as representatives from various departments of the government. The convention meets but once in ten years, primarily for the purpose of electing officers and

board of trustees, more particularly to elect a revision committee which is charged with the responsibility of revising the *Pharmacopoeia* for the coming decade.

The usual reports were made by the respective officers of the convention and, in addition, addresses were presented by the president of the American Medical Association, Dr. Ernest E. Irons, by the president of the American Pharmaceutical Association, Mr. Henry Gregg, and the president of the National Association of Retail Druggists, Mr. F. Royce Franzoni. Mr. Paul B. Dunbar, Federal Commissioner of Food and Drugs, and Mr. C. H. Hamshire, chairman of the British Pharmacopoeial Commission, also addressed the convention.

The 1940 U.S.P. Convention authorized the appointment of a Committee on Constitution and By-Laws to review this material and to report at a special session of the convention in 1942. As you probably know, this special session was held in Cleveland and, at that time, the by-laws, as revised by the committee and approved by the board of trustees, were adopted essentially as presented. However, requirements of the con-

stitution made it impossible to adopt any changes in the latter at that time. Accordingly, one of the important considerations for the recent convention was that of a revised constitution. Copies of the old constitution and the proposed material had been distributed to all organizations and delegates in advance of the meeting so that all who were interested had full opportunity to digest the proposals. The board of trustees had reviewed all of the suggestions, and the careful thought given to this revision was exemplified by the fact that practically every suggestion made by these bodies was unanimously adopted by the convention.

The most outstanding change was elimination of a number of local organizations from representation in the convention. These had been recognized by the constitution beginning with 1900, at which time the convention was incorporated, but recent experience had indicated the necessity of streamlining the convention and eliminating duplicate memberships. In addition, each organization will hereafter have but one representative rather than three, as has been possible up to the present time. Thus the conven-



The American Medical Association exhibit, "Mechanical Quackery," demonstrated by Mr. Oliver B. Field of the Bureau of Investigation of the AMA, was housed in the Emergency Hospital at the Allegheny County Free Fair, August 31 through September 4, 1950, at South Park. The Emergency Hospital was staffed by members of the Allegheny County Medical Society drawn from hospitals in the Pittsburgh area. Also in attendance were nurses supplied by the hospitals. In another room were displayed services of the Allegheny County Medical Society to the community, such as emergency medical call service, speakers' bureau, and motion pictures.

tion of 1960 will be noticeably smaller and it was hoped that it would be better able to take care of the problems of the convention.

The recent convention brought into operation, for the first time, a number of important changes which were made in the by-laws in 1942. Among these were:

1. The increase of the Revision Committee from 50 to 60 members.
2. The appointment of a Director of Revision by the board of trustees prior to the convention rather than having the director elected by the new Revision Committee. This change was made because of the full-time position which was now required by the director and the greater responsibility which he must assume.
3. Nominations for membership on the Revision Committee presented by a nominating committee which submitted a list of 120 candidates, two for each position which was open.

In this connection it may be pointed out that months prior to a meeting a call is issued to all organizations entitled to send delegates to submit names for consideration by the Nominating Committee, together with information pertinent to the individual and bearing upon his ability to meet the demands for certain positions which are to be filled. This delegate would recommend that serious consideration be given at the time of the next convention to recommending medical representatives to the Nominating Committee. It must be remembered that the Revision Committee has considerable responsibility in issuing two *Pharmacopoeias* during the decade, and it evolves upon the medical representatives, as members of the important Subcommittee on Scope, to determine what preparations shall be included in the *Pharmacopoeia*, which has come to be recognized as the ultimate in modern therapeutics. The Executive Committee, representing chairmen of the several subcommittees, had set up a list of categories to which they believed it desirable for the Revision Committee to conform. As previously indicated, two candidates were finally selected for each of these positions and the delegates eventually voted for one of the two names. It will readily be seen that this feature becomes of tremendous importance in the development of a sound *Pharmacopoeia*, since it helps materially in eliminating certain unfortunate practices of previous conventions and helps

to provide specialists for each of the categories which are involved in pharmacopoeial revision.

Twenty medical members were elected to the Revision Committee and forty representing pharmacy and allied sciences. The twenty medical members elected from the states included the following from Pennsylvania, all from Philadelphia: Russell S. Boles, Robert D. Dripps, George E. Farrar, Jr., and Eugene P. Pendergrass.

The officers of the convention for the coming decade are:

- President—Allen H. Bunce, Atlanta, Ga.
Vice-president—Theodore G. Khumpp, New York, N. Y.
Secretary—Adley B. Nichols, Lansdowne, Pa. (re-elected).
Treasurer—W. Paul Briggs, Washington, D. C. (re-elected).

In electing the new board of trustees, two members were chosen to represent medicine, two to represent pharmacy and allied sciences, and two as members at large. The six thus elected are:

- Patrick H. Costello, Chicago, Ill.
Arthur C. DeGraff, New York, N. Y.
Carson P. Frailey, Washington, D. C.
Ernest Little, Newark, N. J.
Austin Smith, Chicago, Ill.
Robert L. Swain, New York, N. Y.

Dr. Lloyd C. Miller was presented as the new Director of Pharmacopoeial Revision. He follows Dr. E. Fullerton Cook who ably served as chairman of the Revision Committee for the past thirty years, and who was associated with the late Chairman Remington for an additional twenty years, thus marking fifty years of valuable service to the *Pharmacopoeia*.

Dr. Miller comes to this important position with a splendid training for present-day pharmacopoeial problems, having been associated with medical research in industry and for a number of years also associated with the Food and Drug Administration. Thus he has the outlook of those who enforce the standards of the *Pharmacopoeia* and also the picture of those who help make those standards as well as with the medical profession which is so vitally interested in what the *Pharmacopoeia* contains. Dr. Miller addressed the convention and showed that he had a splendid grasp of the many problems with which he will be faced.

The convention considered numerous policies and made recommendations to both the incoming board of trustees and the new Revision Committee.

This delegate greatly enjoyed the opportunity of representing the Society and believes that the United States Pharmacopoeial Convention merits the attention and interest of every one of its members.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since July 31. Figures in first column denote county society numbers; second column, State Society numbers.

July 26	Lycoming	142	10275	\$23.00
	Lycoming	143	10276	11.50
Aug. 10	Monroe	41	10277	11.50
	Lehigh	223	10278	23.00
	Greene	28	10279	23.00
	Greene (1949)			15.00
	Lackawanna	285	10280	23.00
15	Luzerne	371	10281	23.00
	Schuylkill	162	10282	23.00
	Westmoreland	208	10283	23.00
	Greene	30	10284	23.00
	Bucks	91	10285	23.00
17	Philadelphia	3043-3053	10286-10296	253.00
	Allegheny	1584-1585	10297-10298	46.00
	Chester	117	10299	11.50
23	Dauphin	254-255	10300-10301	23.00
	Bedford	12-13	10302-10303	46.00
Sept. 1	Chester	118	10304	11.50

CHANGES IN MEMBERSHIP

New (6) and Reinstated (18) Members

ALLEGHENY COUNTY: Joseph R. Kenney and C. Norman Uddstrom, Pittsburgh.

BEDFORD COUNTY: (Reinstated) Victor Maffucci and Harry A. Shimer, Bedford.

BUCKS COUNTY: (R) John E. Barsby, Quakertown.

CHESTER COUNTY: John Benton Thomas, West Chester.

DAUPHIN COUNTY: William P. Goodwin, Steelton; James Lynch, Harrisburg.

GREENE COUNTY: (R) Arthur T. Murray, Nineveh.

LACKAWANNA COUNTY: (R) Earl A. Rebhorn, Scranton.

LUZERNE COUNTY: (R) Max G. Altshuler, Shickshinny.

LYCOMING COUNTY: (R) Leo M. Knauber, Williamsport.

PHILADELPHIA COUNTY: Bernard J. Shuman, Philadelphia. (R) Alfred M. Bongiovanni, Drexel Hill; George W. Deitz, III, Henry J. Dudnick, Joseph E. Forman, Hayward R. Hamrick, Abram Kanofsky, Karl John Kurz, Joseph Howard Litz, and Ernest A. Spiegel, Philadelphia.

SCHUYLKILL COUNTY: (R) Joseph F. Matonis, Schuylkill Haven.

WESTMORELAND COUNTY: (R) J. Thomas Allison, New Kensington.

Resignations (8), Transfers (3), Deaths (14)

ALLEGHENY: *Deaths*—James McMaster Long, Norwalk, Conn. (Columbia Univ. '04), August 1, aged 73; Frank H. Rimer, Pittsburgh (Univ. of Pgh. '11), August 3, aged 71; William N. Marshall, Aspinwall (Jeff. Med. Coll. '84), August 10, aged 90.

BEAVER: *Resignation*—Loyal K. Wilson, Waco, Texas.

BLAIR: *Deaths*—George R. Good, Altoona (Univ. of Pa. '33), July 31, aged 41; William H. Meminger, Altoona (Med.-Chi. Coll. '06), August 7, aged 69.

CAMBRIA: *Death*—William Joseph Killius, Johnstown (Med. Coll. Va. '26), August 3, aged 55.

CHESTER: *Transfer*—Henry P. Close, Coatesville, from Philadelphia County Society.

DAUPHIN: *Transfer*—Thomas J. Fritchey, Harrisburg, from Philadelphia County Society.

ERIE: *Death*—Guy C. Boughton, Erie (Univ. of Vt. '00), August 9, aged 73.

JEFFERSON: *Death*—Sylvester S. Hamilton, Punxsutawney (Jeff. Med. Coll. '31), July 6, aged 50.

LACKAWANNA: *Death*—John W. Lyons, Jessup (Med.-Chi. Coll. '11), July 30, aged 65.

LUZERNE: *Transfer*—Howard T. Fiedler, Retreat, from Montour County Society.

LYCOMING: *Death*—James D. Beach, Williamsport (Jeff. Med. Coll. '95), July 3, aged 80.

PHILADELPHIA: *Resignations*—Ned T. Raker, Philadelphia; William J. Rhinehart, Philadelphia; William L. Drake, Jr., Philadelphia; Marguerite M. Devine, Kansas City, Kan.; William H. Shoffstall, Philadelphia; Nelle E. Draper, Ardmore; George L. Brown, Charlotte, N. C. *Deaths*—Robert F. Ridpath, Philadelphia (Med.-Chi. Coll. '99), August 10, aged 74; William A. Swalm, Philadelphia (Univ. of Pa. '11), August 11, aged 62.

SCHUYLKILL: *Death*—Thomas C. Rutter, Schuylkill Haven (Univ. of Pa. '00), August 14, aged 77.

WASHINGTON: *Death*—James R. McNinch, West Alexander (Eclectic Med. Coll. '01), August 16, aged 75.

Medicine is the only profession that labors incessantly to destroy the reason for its own existence.—JAMES BRYCE.

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Do you have any puzzling diagnostic problems to solve or a paper to prepare for professional or lay audiences? If so, why not take advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania?

The library consists of a collection of over 102,000 reprints and tear-sheets from various publications, which are filed for your use. Requests for material should be addressed to the Librarian, 230 State St., Harrisburg, Pa., and a package will be mailed to you for a loan period of two weeks. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material.

The following requests were filled during the month of August:

Hospitals	Undulant fever
Medical education	Jagziekte
Rh-negative mother	Acute myocarditis
Treatment of migraine	Xerostomia
Diabetes mellitus	Tuberculosis of the hip
Ventricular tachycardia	Problems of epilepsy
Self-medication	Personality
Rorschach test	Psychiatric problems
Plans for atomic disaster	Carcinoma of the vulva
Atomic energy in medicine	Tumors of the thigh
Rubella and pregnancy	Sympathectomy
Experimental diabetes	Circumcision
Heredity	Angiomas
Thyroid preparations	School nurse
Thymol turbidity test	Twins
Public health	Health in rural areas
Diabetes	Scleroderma
Progress of medicine	Periarteritis nodosa
Cancer clinics (2)	Lupus erythematosus
Physiology of diabetes	Allergies in industry
Cancer of the prostate	Post-traumatic neuroses
Strephosymbolia	Fluid balance

Use of proper lighting in schools
Child-caring agencies and institutions in Pennsylvania
Intestinal obstruction due to herniation of small bowel

Clinical studies in the use of myanesin
Treatment of deafness with vitamins
Sprue syndrome
Treatment of alopecia areata
Prevention and control of tuberculosis
Relation of physician to patients
Hospitals in the United States
Estrogen therapy in carcinoma of ovary and uterus
Hormones in the therapy of diabetes in pregnancy
Benzodioxan test for pheochromocytoma
Anticoagulation therapy in surgery
Schools for medical technicians in Pennsylvania
Tuberculosis among student nurses
Convalescent homes in Pennsylvania
Streptomycin in tuberculous meningitis
Evaluation of blood protein and factors in atopic eczema

Anuria, management of prostatic hypertrophy, and carcinoma of the prostate

Local anesthetics used as dental anesthesia
Allergic reactions to novocain
Drug therapy in multiple sclerosis
Anatomy and physiology of the hypothalamus
Mesothelioma of the peritoneum
Relation of tonsillectomy to poliomyelitis
Use of ACTH and cortisone
Saddle embolus at the bifurcation of the aorta
Management of occipitoposterior position
New developments in treatment of syphilis
Administration of fluids in pre- and postoperative cases

Trauma as a cause of breast carcinoma
Hospital air-conditioning
Injection therapy for internal hemorrhoids
Thermal coagulation of serum proteins
Triethylene melamine in the treatment of Hodgkin's disease

Treatment of hemangiomas
Diaphragmatic hernias in infants

ANSWER CURRENT QUESTIONNAIRES PROMPTLY

Officers and committee members of your state medical society regret the necessity for sending questionnaires to every doctor of medicine in Pennsylvania, society and non-society members alike. Each may receive more than one questionnaire before the end of 1950. They are essential to the physical welfare of civilians and soldiers, all of whom may be suddenly exposed to injury or death during war-related emergencies.

Each physician may be needed; therefore, his whereabouts, his experience and availability must be known to those who plan in advance to meet disaster, wherever or in whatever form it may occur.

Please complete and return questionnaires promptly.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Course Available

During the coming school year, the University of Pennsylvania will conduct three courses in the diagnosis and treatment of cancer.

The Cancer Control Division of the Pennsylvania Department of Health will pay the tuition of each registrant and will provide \$200 for living expenses.

Each course will be two weeks long and will consist of lectures, panel discussions, and clinical demonstrations. Four evening lectures will be given by outstanding authorities in the field of cancer in various parts of the country.

The dates for the courses are: October 23 to November 4, 1950; January 22 to February 3, 1951; and April 9 to 21, 1951. Each class is limited to 15 and application blanks may be secured by writing to the secretary of the Cancer Commission of the University of Pennsylvania, Hospital of the University, 3400 Spruce Street, Philadelphia.

New Film Available

Rehabilitation of laryngectomized patients is the subject treated in the film "We Speak Again" which was sponsored jointly by the Massachusetts Eye and Ear Infirmary, the American Cancer Society, and the society's Massachusetts Division.

"We Speak Again" opens with animated sequences describing a laryngectomy. The film follows a patient from the time when he is told of an impending operation until he is able to resume normal life through the use of his esophagus to produce the necessary sound for articulation by his speech organs. The patient is shown during the period of his instruction when his ability to vocalize progresses from painfully uncontrolled monosyllables to clearly delivered sentences.

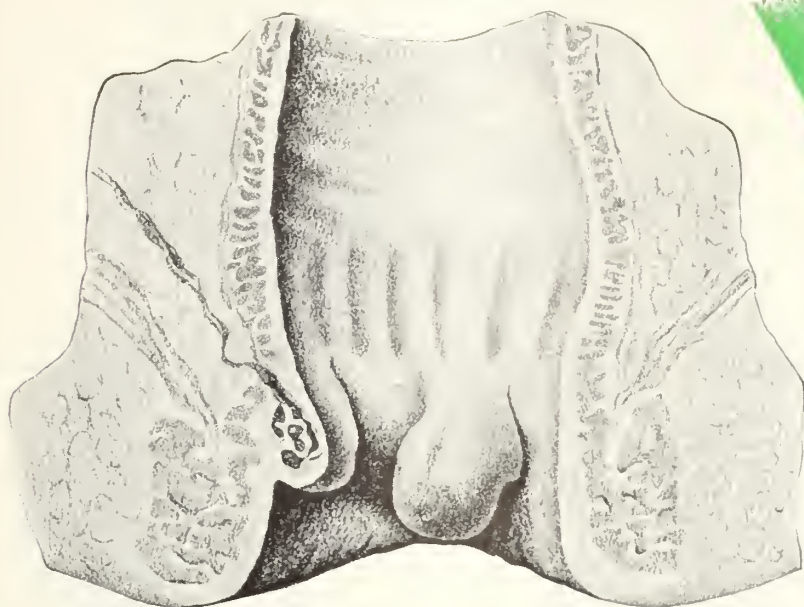
The patience of the teacher, who had herself undergone a laryngectomy and experienced rehabilitation through esophageal speech, is matched by the determination of her student to restore his powers of communication. The film projects the perseverance and courage of both teacher and student through the long process of re-education.

Prepared primarily for professional audiences, "We Speak Again" is suitable for showing to state and county medical societies, hospitals, public health staffs, schools of nursing, and medical and nursing conventions. Its running time is ten minutes. It is available for loan or purchase from Sturgis-Grant Productions, Inc., 314 East 46th St., New York 17, N. Y. The print cost is \$80. Rental fee is \$7.50.

Package Library

The Medical and Scientific Library of the American Cancer Society has established a package lending library of reprints on cancer covering the majority of articles published in the past ten years. The service is available through the Pennsylvania Division Office, Hall Building, Harrisburg, to doctors and research workers requesting it.

Because of the volume of material, only specific requests will be honored. Reprints must be returned within ten days.



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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

HOSPITAL authorities have long evinced real concern over the possible hazard of tuberculosis in the hospital environment, and today there is evidence of a growing demand for the routine use of more thorough measures of prevention, many of which would formerly have been considered experimental or extraprecautionary.

TUBERCULOSIS AMONG HOSPITAL PERSONNEL

More than a decade ago published reports demonstrated for the first time that the tuberculinization of the young adult population in the United States was significantly below 100 per cent. This downward trend in the proportion of reactors which is still being reported has been noted in studies of entering medical and nursing students.

On the other hand, according to evidence which has accumulated during the past decade, the acquisition of primary tuberculous infection among hospital personnel is extremely rapid, compared with the rate of infection of other young adults.

It is known that active tuberculosis exists unrecognized in the general population. The experience of Selective Service and mass x-ray surveys of civilian populations has demonstrated that the prevalence of active tuberculosis in our adult population is roughly 500,000 cases, of which an estimated one-half are unknown to the health authorities.

If this is true, the nurse is regularly exposed to unknown tuberculosis in caring for patients on the general medical and surgical wards at an age when her sex suffers high morbidity and mortality from this disease. Most authorities agree that the undiagnosed tuberculous patient in the general hospital is one of the chief sources of infection today. Studies of medical students show that hazards of infection unrelated to clinical work also exist, as in autopsy or laboratory work.

Admittedly, the relative importance of factors responsible for development of tuberculous disease is a complex subject. In most cases infection by the tubercle bacillus leads to a reaction which is innocuous. It is believed that frequent and heavy exposure, however, will overcome immunity.

In the final analysis, tuberculosis as an occupational hazard among hospital personnel must be measured in terms of active disease suffered by these persons and not by the amount of tuberculous infection incurred by them. The problem is to ascertain whether or not tuberculosis develops more frequently among persons working in a hospital environment than elsewhere. Although there is no unanimity on this point, many authorities do believe that nurses suffer a greater hazard of developing tuberculosis than do other young women.

In evaluating the tuberculosis risk in the hospital, however, it must be realized that more frequent case finding in hospitals will result in higher morbidity rates in these institutions than in the general population. Also, most hospital studies show very low mortality rates among their personnel, which may be attributed to early diagnosis and proper treatment.

Although most authorities agree that tuberculosis is an occupational hazard for medical and nursing personnel, agreement ends and controversy begins when the effect of the tuberculin reaction on the development of active tuberculosis is discussed. Studies show little agreement,

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but many indicate an excessive morbidity in a relatively brief period after conversion from a negative to a positive reaction.

In any analysis of tuberculosis morbidity in relation to the original tuberculin reaction, however, it must be noted that, first, nonreactors represent a group more susceptible to tuberculosis because they have not been subjected to infection, whereas the reactors have already met the test of infection; second, sensitivity to tuberculin may be lost more frequently than has been realized. If this is true, we may be considering among original nonreactors some persons who have lost sensitivity; therefore, resulting proportions may not be valid. Third, in evaluating morbidity trends, considerable numbers of persons must be studied because of the low morbidity from tuberculosis in our population. Fourth, the type of tuberculosis seen in the United States may differ from that in other countries. Certain authorities have noted that young women in this country appear to be highly resistant because of genetic environmental, or nutritional factors.

In many general hospitals, efforts have been made in recent years to minimize the hazards of infection for the student nurse by shortening the 'raining on the tuberculosis service or by giving it to reactors only. Aseptic techniques have been increasingly stressed when caring for tuberculous patients. Nevertheless, incidence of infection in many of the hospitals has not decreased appreciably, and the difficulty appears to lie with the admission of patients with undiagnosed tuberculosis.

It is undeniable that exposure to undiagnosed tuberculosis is high in many general hospitals. Autopsy studies reveal unsuspected tuberculosis in many older persons dying from other diseases. X-raying of admissions formerly presented a budgetary problem, but today the cost is considerably reduced by the use of miniature x-ray film. The cost to hospitals would probably be

offset by the reduction in compensation paid to nurses in whom tuberculosis develops. It seems obvious that more attention should also be paid to such sources of infection as the autopsy room.

Considerable disagreement prevails over the degree of aseptic technique to be used when caring for the tuberculous patient. Complete isolationist technique is not always possible because many patients are ambulatory. Patients with arrested disease may occasionally produce positive sputum, and such persons can never be rehabilitated economically or socially if kept in isolation.

Many authorities believe that BCG is not the answer to protection since studies by them have shown no significant difference in morbidity between positive and negative reactors and because protection is not complete. All agree that the tuberculous patient should be isolated on separate wards in the general hospital.

Undoubtedly, technique should be stressed constantly in order that the nurse may not grow careless. It is probably true that many doctors serve as bad examples by not adhering to the technique which they themselves recommend. Some believe that the tuberculin-negative student nurse should not be allowed to care for tuberculous patients, but this is hardly a practical suggestion.

It is quite generally agreed that BCG should be given the tuberculin nonreactor as an adjunct to preventive technique, particularly in situations where the tuberculous patient is noncooperative, as in the mentally deficient.

Although variations appear in the programs reported, the consensus seems to be that six months represent the maximum time which should be allowed to elapse between tuberculin testing or x-raying of hospital personnel.

Tuberculosis Among Hospital Personnel, Eleanor C. Connolly, M.P.H., National Tuberculosis Association, 1950.

CORRECTION

The statement appearing on page 853 of the August issue of the *Journal* to the effect that American Medical Association *Fellowship* dues in 1951 would be \$2.00 is incorrect. The amount will be \$5.00. It will be remembered that AMA *dues* in 1951 will be \$25, which will include the cost of a subscription to the weekly *Journal AMA*.

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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street, Indiana

INAUGURAL ADDRESS



It is my desire first to express my deep appreciation and sincere respect for my predecessors in this important office of state president. Their efficient leadership, challenging objectives, untiring efforts, and splendid accomplish-

ments through the years have inspired and assisted our Woman's Auxiliary to The Medical Society of the State of Pennsylvania to achieve its present significant position as an alert, alive, progressive, and active helpmeet to our medical society in its fight to preserve our system of free enterprise in a free and democratic country, the envy of the world today.

Strange to say, I was president of the Woman's Auxiliary to the Westmoreland County Medical Society during World War II. Although I distinctly appreciate the honor of being elected president of our splendid state auxiliary, nevertheless I definitely recognize the serious nature of its program and feel most responsible in assuming its highest office during another period of turmoil. I shall need the individual cooperation of each auxiliary member in the work which lies ahead. I trust that together we shall be able to help win the battle that at present is being waged against our democratic way of life—at home and abroad.

I need not tell you that this Atomic Age is a desperately unstable time in which to live—a time that is again trying men's souls as well as racking their bodies. The present world situation is an acute phase of the struggle in which our liberty and our whole way of life are at stake. Once again we have reached the place in our national history where, if we want freedom, we must be determined and willing to preserve freedom; business as usual, politics as usual, and wishful thinking must be abandoned promptly.

Our traditional form of American liberty consists of each citizen handling his own business on the basis of personal responsibility and individ-

ual initiative. It would be well for us to rededicate ourselves to the principles and ideals on which our nation was founded. Definite protection, and not intrusion on the security that responsible people are able to attain individually or through voluntary cooperation with others, should be one of the major purposes of our government.

American doctors are proud of our nation's world leadership in good health, which is tremendously important not only to the profession but to millions of Americans. The American Medical Association is the largest medical association in the world with 144,500 members. The House of Delegates, the policy-making body, acts on vital issues affecting the health and welfare of the people of the United States. Spectacular scientific and technical progress with equally significant medical and surgical progress has been made by the medical profession to date. But the medical profession, keeping pace with new developments in diagnosis and treatment, must now also protect our American way of life, insuring moral and spiritual well-being, in addition to protecting the people's physical health. The bureaucratic scheme of compulsory health insurance, alias socialized medicine, alias political medicine, is a government-dictated medical system, the first major objective in the development of a socialist state, dominated by a small group of selfish politicians with a grasping lust for power to control all fields of human endeavor under a totalitarian government plan. Accordingly, American medicine is no longer the concern of medical people alone, but it has become the compelling concern of all people interested in saving our freedom and the system of individual initiative unique to the United States of America.

Let us examine the record and see what has been accomplished by the medical profession. The achievements of the past, according to Elmer L. Henderson, M.D., the newly elected president of the American Medical Association,



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are as follows: a continuous fight waged against disease and premature death with the notable result that in the past 50 years the death rate has been cut almost in half, with 19 years added to the individual's life expectancy, the present life span now considered to be 68 years; maternal and infant mortality rates the lowest in the history of America, with death rates for mothers in the United States the lowest of any nation in the world; pneumonia, influenza, and tuberculosis death rates lowered 20 per cent, with typhoid fever, diphtheria, and smallpox practically eliminated, and with effective methods available for the prevention, control, and treatment of infectious disease.

Among the present achievements, Dr. Henderson lists new and revolutionary methods of examination, diagnosis, and treatment; new drugs, anesthetics, surgical techniques, vaccines, and serums; facts about nutrition, equipment, and facilities; methods of sanitation, public hygiene, and medical education; continual expansion and improvement of the hospital system; raising of standards in medical schools resulting in better medical schools; more doctors, with the ratio of doctors to the population higher in the United States than in any other nation on earth; technologic improvements which aid in providing more medical care; and medical economics, voluntary health insurance plans providing prepaid medical care for 70 million people, thereby taking the economic shock out of illness and increasing the utilization of medical care by all income groups.

To further quote Dr. Henderson, the future plans of the medical profession include a continued increase in voluntary health insurance to reach 90 million people with the problem of increased medical service largely resolved; victory over cancer, infantile paralysis, arthritis, rheumatic fever, premature heart disease, and high blood pressure achieved by doctors *but not by politicians*; the continued reduction to an absolute minimum by new methods of prevention, control, and treatment of pneumonia, tuberculosis, influenza, the common cold, and other infectious conditions; new knowledge concerning the human mind as well as the human body; and the continuance of the medical profession to minister to the sick, to relieve human suffering, and to uphold the ideals found in good medicine and in sound Americanism.

For us as auxiliary members, the accent in our

thinking today must definitely be on individual responsibility, for the threat against the continued progress in medicine has not vanished. We must continue our endeavor to decisively defeat compulsory health insurance measures. We must support the medical research program of our state medical society. As individuals, we must do everything possible to elect candidates who will further the aims of the medical profession. The slogan of the Woman's Auxiliary today might well be "Serving our doctors and protecting American health."

Every auxiliary member in this Atomic Age should be well informed concerning legislation affecting the medical profession; she should be intensely aware of the present state of affairs, of what is happening in America today; she should be interested and active in civil projects, working within her community for better public relations; she should be an alert guardian of community health; she should tell the true story of medical research; she should read worthwhile current literature and know what is being said about the medical profession in order to agree or refute; she should attend and participate in all auxiliary meetings whenever possible; and she should see that eligible voters are registered and, if necessary, take them to the polls to vote.

As auxiliary members we must assist through a live-wire working program in preserving the great institution of private medicine. We should present and promote educational programs, using information and speakers supplied by the American Medical Association, the National Auxiliary, the State Medical Society, and the State Department of Health. We should sponsor in each community at least one outstanding annual Health Day program for the public. We should consult superintendents of schools about essay or poster contests and furnish them with material on voluntary health insurance plans. We must continue the drive for new members and the reinstatement of delinquent members. We must try earnestly to meet and exceed the quota for *Today's Health* and to place this magazine in all public offices. We must promote all programs outlined by the American Medical Association and its component, The Medical Society of the State of Pennsylvania, as well as the challenging projects that will be presented by the newly appointed chairmen of our state auxiliary.

In addition, auxiliary members should participate in recognized civic projects, such as the

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Mid-Century White House Conference, blood banks, health maintenance clinics, volunteer services in state health clinics, scholarships for medical students and nurses, community health assemblies, school health councils, and community welfare drives.

In closing, I wish to emphasize the theme for this administration, "Personal freedom cannot endure without individual responsibility," and to give to all of you the Presidential Oath of Office which was used for the first time in the history of the American Medical Association when Dr. Elmer L. Henderson of Louisville, Ky., was inaugurated in a public ceremony held in San Francisco on June 27, 1950, which was broadcast over the American Broadcasting Company and the Mutual Radio Networks: "I solemnly swear that I shall carry out the duties of the office of President of the American Medical Association to the best of my ability. I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to the task of bringing increasingly improved medical care within the reach of every



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I. M. WAGGONER, M.D., MEDICAL DIRECTOR

citizen. I shall uphold the Constitution of the United States and the Constitution and By-Laws of the American Medical Association at all times. I shall champion the cause of freedom in medical practice—and freedom for all my fellow Americans. I do solemnly swear that I will discharge the duties of this office to the best of my ability, so help me God.”

As members of the Woman’s Auxiliary to The Medical Society of the State of Pennsylvania, we in turn promise to adopt this oath as our own when we repeat our auxiliary pledge, “I pledge my loyalty and devotion to the Woman’s Auxiliary to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals.”

(Mrs. Howard H.) MARY STEEL HAMMAN,
President.

SAN FRANCISCO CONVENTION

The twenty-seventh annual meeting of the Woman’s Auxiliary to the American Medical Association was held from June 26 to 30 in San Francisco, Calif., with the Fairmont Hotel as the official headquarters for all of the auxiliary meetings and for most of the social affairs. Registration took place in the hotel lobby between 12 noon and 4 p.m. on Sunday, June 25, when badges, programs, and tickets for all functions were secured by the delegates. Members of the hospitality committee of the hostess group assisted in making the visits pleasant and profitable for the delegates and the wives and guests of physicians who attended this outstanding convention, which ran concurrent with the eventful celebration of California’s admission as a state in our Union. On Sunday afternoon and evening, meetings in charge of the respective chairmen were held by the nominating committee, the committee on revisions, and the finance committee.

Mrs. David B. Allman, the national president, held a meeting of the AMA Auxiliary board of directors on



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Monday morning, which was followed by a luncheon. Round table discussions were also held from 9 a.m. to 3 p.m. consecutively, with the following chairmen presiding during the sessions: Mrs. Herbert Johnson, *Today's Health*; Mrs. Bruce Schaefer, legislation; Mrs. Paul C. Craig, public relations; and Mrs. Leo J. Schaefer, program.

The following intensive program was conducted on June 27 and 28, with the national president, Mrs. Allman, presiding, making introductions, presenting the president-elect, Mrs. Arthur A. Herold, and formally addressing the convention; with the constitutional secretary, Mrs. Harry M. Gilkey, calling the roll and reading the minutes; and with Mrs. Clifford Long presenting the convention chairmen and making announcements.

During the opening session on June 27, the invocation was offered by the Rev. Dr. T. Christie Imes, pastor of Calvary Presbyterian Church. The auxiliary pledge was led by Mrs. Luther H. Kice, immediate past national president. Greetings were extended by Theresa Meikle, superior court judge, and by William L. Bender, M.D., president of the San Francisco County Medical Society. An address of welcome was delivered by Mrs. William R. Molony, Jr., president of the Woman's Auxiliary to the California Medical Association, and the response was given by Mrs. Truman Caylor, past president of the Woman's Auxiliary to the Indiana Medical Association. The convention rules of order were read by Mrs. Carl N. Neupert. The credentials

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and registration report, with 1455 delegates registered on Tuesday, was presented by Mrs. Norman Epstein.

Reports were made during the morning session by the following officers: Mrs. Arthur A. Herold, president-elect; Mrs. Harold F. Wahlquist, first vice-president; Mrs. Henry Garnjobst, second vice-president; Mrs. W. E. Hoffman, third vice-president; Mrs. Mason G. Lawson, fourth vice-president; Mrs. George Turner, treasurer; Mrs. Harry M. Gilkey, constitutional secretary; and the auditor. During the afternoon session, Mrs. Allman gave the report of the board of directors, and reports were presented by the following standing committee chairmen: finance, Mrs. Scott C. Applewhite; *Today's Health*, Mrs. Herbert W. Johnson; legislation, Mrs. Bruce Schaefer; organization, Mrs. Harold F. Wahlquist; program, Mrs. Leo J. Schaefer; publications, Mrs. James P. Simonds; public relations, Mrs. Paul C. Craig; and revisions, Mrs. Eustace A. Allen. The reports of the following special committee chairmen were then heard: reference, Mrs. Rollo K. Packard; historian, Mrs. Jesse D. Hamer; central office and *Bulletin* circulation, Miss Margaret Wolfe, executive secretary; and nominations, Mrs. Luther H. Kice. The Woman's Auxiliary members were invited to attend the opening meeting of the American Medical Association which was held at 8 p.m. in the ballroom of the Palace Hotel.

On Wednesday, June 28, in addition to the formal opening, Mrs. Ralph Eusden conducted a memorial service, resolutions were presented by Mrs. Louis K. Hundley, and reports of state presidents were given.

The election and installation of officers took place

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GYNECOLOGY—Intensive Course, two weeks, starting October 23. Vaginal Approach to Pelvic Surgery, one week, starting November 6.

OBSTETRICS—Intensive Course, two weeks, starting November 6.

MEDICINE—Intensive General Course, two weeks, starting October 2. Gastro-enterology, two weeks, starting October 16. Gastroscopy, two weeks, starting October 23. Electrocardiography and Heart Disease, four weeks, starting October 2.

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during the afternoon session, after the second reading of the report of the nominating committee by Mrs. Kice. This was followed by the presentation of the president's pin by Mrs. Rollo K. Packard and the inaugural address by Mrs. Arthur A. Herold, newly elected national president. A total of 1703 delegates were reported as registered, with 23 from Pennsylvania. The convention courtesy resolutions were presented by Mrs. F. Justin McCarthy. The final reading of the minutes by Mrs. Gilkey was followed by adjournment. At 4 p.m. a meeting of the new board of directors was held, with Mrs. Herold presiding.

On Thursday morning, June 29, Mrs. Herold presided at a conference of the national president, president-elect, chairmen of standing committees, and state presidents and presidents-elect.

Of particular significance during the convention was the panel discussion on public relations, which was largely attended. It was conducted by our own Mrs. Paul C. Craig, capable chairman of public relations for the AMA Auxiliary and efficient past president of our own state auxiliary. The following points were especially stressed: that the securing of resolutions from lay organizations is being admirably accomplished by our woman's auxiliary, and that the only way to win the battle against political medicine is on the local level,

by getting down to grass root support and securing more workers from other national groups to promote voluntary health insurance plans.

The following instructions were given concerning the Woman's Auxiliary and the National Education Campaign activities: give all auxiliary members a sufficient supply of resolution forms for furnishing lay organizations with seven copies of each resolution; have each resolution read aloud before the groups so that its arguments and opinions may bring about a helpful reaction to our cause; write thank-you notes to organizations giving auxiliary support (if possible, an auxiliary member should mail the completed resolution to be sure that the important six—congressman, two United States senators, President, state medical society, and Whitaker & Baxter—each get a copy and that one is kept for the files); obtain permission and promptly supply dentists' and lawyers' offices with literature; and in the coming elections, in order to defeat state socialism through its whipping-post, socialized medicine, every auxiliary member must work with her husband and write letters, address envelopes, make speeches, and get out the vote to elect candidates who favor the voluntary system of medical care.

As for planning public relations projects in a community, it was suggested that members ask their med-

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ical society to evaluate these projects; sponsor an essay contest; build good will with the nursing groups through personal contact and interest; learn what is being done and offer assistance to each county medical society in caring for the chronically ill and seeing that adequate care is given to the mentally ill; assist the county medical society by securing speakers and publicizing radio programs; and secure authentic health films from the state medical societies, the state departments of health, the AMA Committee on Medical Motion Pictures, and the state or university extension services.

The Pennsylvania delegates were happy to have our own Mrs. Charles Shafer elected to the nominating committee and also elected constitutional secretary of the AMA Auxiliary.

The social affairs enjoyed during this convention were as follows: On Monday, June 26, from 4 to 6 p.m., a tea honoring the national president, Mrs. Allman, and the national president-elect, Mrs. Herold, was held in the Huntington Hotel with the members of the national board of directors, the state presidents and presidents-elect, delegates, and other auxiliary members as guests. On the same day golf was played at the Presidio Golf Club. Arrangements were also made for guest cards for swimming in the pool of the Woman's Athletic Club.

At 12:30 p.m. on Tuesday, June 27, 381 members attended a luncheon in honor of the past national presidents, which was held in the Fairmont Hotel with Mrs. Allman presiding and with Ernest B. Howard, M.D., assistant secretary of the AMA, as the guest speaker. Dr. Howard commended the auxiliary on its 54,000 membership and urged the members to help promote the securing of a larger number of subscriptions to *Today's*

Health; to cooperate with the Mid-Century White House Conference to prevent it from becoming Oscar Ewing's political football; and to work with concentration on medical bills. He stated that doctors are citizens and that, if the 145,000 members of the AMA register and vote, they will be a political force with which to reckon.

On Wednesday, June 28, at 2:30 p.m., the annual luncheon honoring Mrs. Allman and Mrs. Herold was held in the Mark Hopkins Hotel, with Mrs. Jesse D. Hamer, past president, presiding. Guest speakers included officers of the AMA. On Thursday, June 29, the annual dinner of the Auxiliary was held at 7 p.m., with Mrs. Clifford Long presiding. At 9 p.m., a reception and ball in honor of the new president of the AMA, Elmer L. Henderson, M.D., was held in the Gold Ballroom of the Palace Hotel.

Sightseeing trips were conducted on Monday and Thursday, June 26 and 29, as follows: around San Francisco; to Chinatown and the Fisherman's Wharf; across the Golden Gate Bridge and into Marin County to Muir Woods; to Stanford University; and over the San Francisco-Oakland Bridge to the University of California campus.

We found ourselves welcome and much at home while in San Francisco, which is a friendly city with a distinct and sparkling personality, with much to be seen of historic as well as of modern interest, and with every type of entertainment offered. The climate was delightful, the sight-seeing trips interesting and enlightening, and the shops, restaurants, and stores modern and inviting.

We are told that the worth of a convention is measured by the lessons learned and the growth of those who attend. We thoroughly appreciated our time spent

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1. *Wüthering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, *Am. J. M. Sc.* 209: 33-41 (Jan.) 1945.

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at the AMA convention, where meetings were friendly with folks happily greeting one another, and where the addresses informed and inspired all of us. We have brought back many enjoyable, unforgettable, and pleasant experiences and memories of places visited, friendships made, distances traveled, and lessons learned—in short, it has been time very agreeably and profitably spent.

(Mrs. HOWARD H.) MARY STEEL HAMMAN,
President.

EXCERPTS FROM EDITORIAL IN MAY 15 ISSUE OF THE UNITED MINE WORKERS' JOURNAL

On the medical question, labor had better begin to think, because if resentment of the voters to national medicine in one-third of the states proves as beneficial to reactionary candidates as in the case of Smathers, the problem of repealing the Taft-Hartley Law—so long as both are linked in the Truman program—will be three times as difficult.

Regardless of how lightly President Truman may seek to brush off the Pepper defeat, the fact remains

that the over-all resentment against Pepper crystallized as a result of Pepper's all-out support of the Truman program.

Pepper had to bear the brunt of all the fault-finding leveled at the Brannan Plan, foreign aid, give-away money, point four, lowering of tariffs, government extravagance, "Commie" influence in government, Kansas City graft, FEPC, repeal of the Taft-Hartley Law and, of course, national medicine.

The heretofore unorganized vote, as a result of the Truman medical plan, the FEPC, the raging "Commie" publicity, and bitterly contested Brannan Plan, was activated into resentful political action as never before—resulting in a record vote.

In 44 years of covering political campaigns in the nation and in many states, your editor has never witnessed such effective and productive quiet solicitation of votes as demonstrated by Florida doctors, druggists, dentists, hospital staffs, insurance companies, and pharmaceutical representatives, aided and abetted by other professional men.

Funds were quietly raised. Golf matches, poker games, bridge parties, and every form of contact which could be conceived and arranged were executed by the medical, drug, and hospital fraternity to convince the people that epidemics would be the order of the day, plus bankruptcy, in the event the proposed Truman medical plan—which Pepper was supporting—was enacted into law.

Generally speaking, the people in the East, North and West look upon Florida as a state of aged pensioners in need of medical attention that they cannot afford. This is only partially true as affecting the aged, but they do not constitute an appreciable percentage of the voters.

Pepper was up against an unreasoning wall of voters on this question and the more he said in support of national medical aid the more votes he lost.—*Journal of the Indiana State Medical Association*, August, 1950.

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The New York *Daily News* of September 13 defines George Bernard Shaw, 94-year-old dramatist who recently suffered a fractured femur, as a socialist of many years' standing, and at the same time points out that he discards the socialist medicine of Great Britain and insists on private room accommodations with the services of specialists.

The *News* ends its 150-word comment on the inconsistent "wealthy old rooster" with this paragraph: When top-drawer Socialists like Shaw, Attlee, and Bevin can't take their own brand of Socialist medicine, just how good or how desirable for anybody is that medicine?



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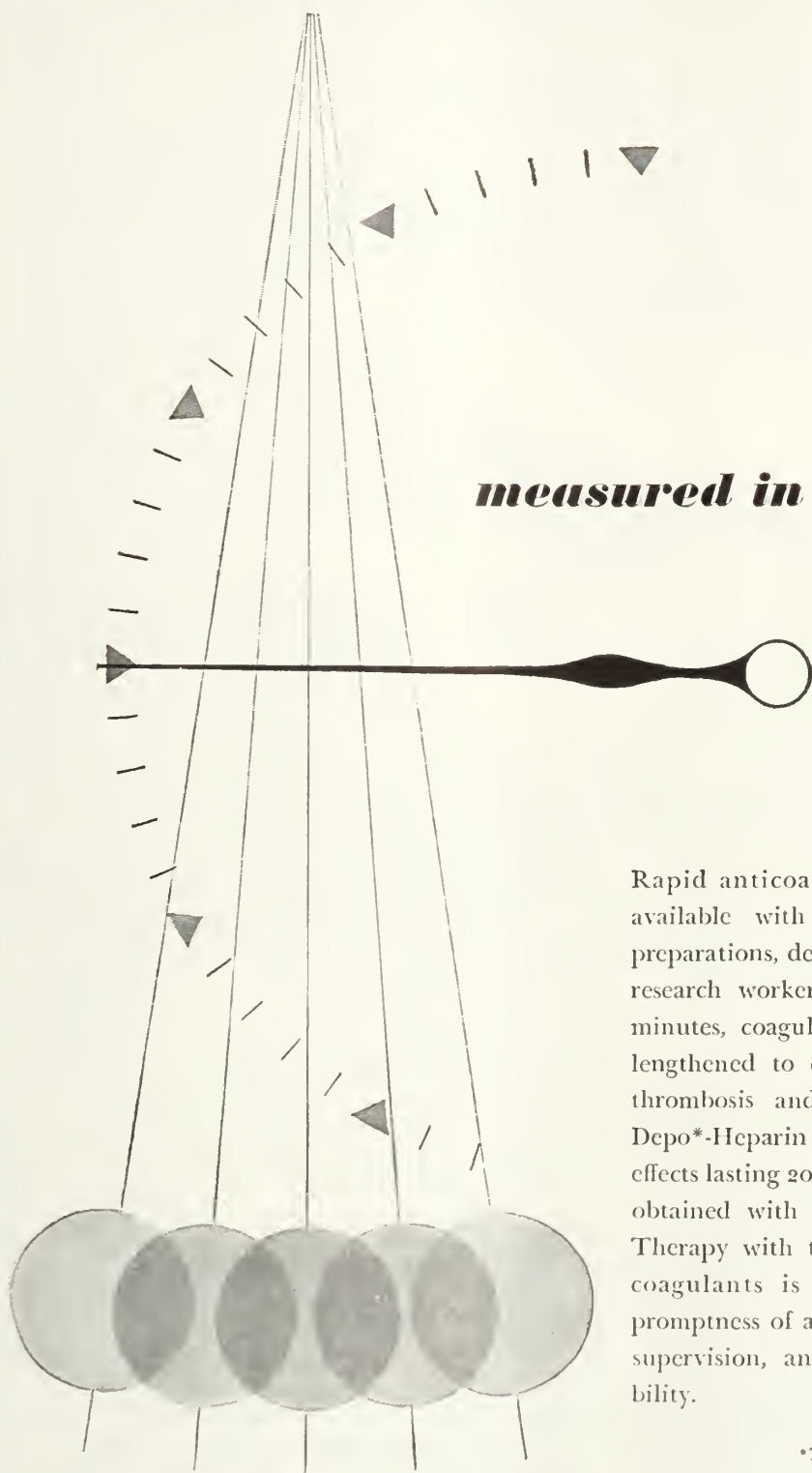
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MEDICAL NEWS

Births

TO DR. AND MRS. CLYDE F. NEWMAN, JR., of Wayne, a son, John Winslow Newman, September 4.

TO DR. AND MRS. JAMES F. GALBALLY, of Philadelphia, a daughter, Elizabeth Ann Galbally, August 9.

Engagements

MISS DENISE MARIE RYAN, of Wynnewood, to Mr. Thomas Ryan Quinn, Jr., son of Dr. and Mrs. T. Ryan Quinn, of Pittsburgh.

MISS NANCY LEE HARLAN, of Bywood, to William H. Annesley, Jr., M.D., son of Dr. and Mrs. William H. Annesley, of Philadelphia.

MISS JEAN HELEN CRAMTON, of Jenkintown, to Mr. James Jamison Waygood, Jr., son of Dr. and Mrs. James J. Waygood, of Philadelphia.

MISS LOUISE LAMEYER, of Boston, Mass., to Mr. Karl M. Houser, Jr., son of Dr. and Mrs. Karl M. Houser, of Penn Valley. Mr. Houser is attending the Medical School of the University of Pennsylvania.

Marriages

MISS JANE ELIZABETH KREMER, of Harrisburg, to Mr. William Lemmon Martin, Jr., son of Dr. and Mrs. William L. Martin, of Merion, September 15.

MISS EUGENIA EPTING DILLON, daughter of Dr. and Mrs. Edward S. Dillon, of Penn Valley, to Mr. Eric Alexander Pearson, Jr., of Philadelphia, September 16.

MISS MARY ELLISON, daughter of Dr. and Mrs. Richard T. Ellison, of Philadelphia, to Mr. Henry Cornwall Hastings, of Springfield, Mass., September 15.

MISS NANCY ROSS SKILLERN, daughter of Dr. and Mrs. Samuel R. Skillern, Jr., of Cynwyd, to Mr. Robert Garrison Lee, son of Dr. and Mrs. Ruland W. Lee, of Maplewood, N. J., September 23.

MISS AMY AUSTIN, daughter of Dr. and Mrs. J. Paul Austin, of Barren Hill, to Mr. John Brockie Lukens, son of Dr. and Mrs. George T. Lukens, of Conshohocken, September 23.

Miscellaneous

HARRY H. NEGLEY, JR., M.D., of Huntingdon, recently took advanced training in surgery at the Cook County Graduate School of Medicine in Chicago.

WILLIAM J. SCHILLING, JR., M.D., clinical director of Warren State Hospital, has been appointed superintendent of Torrance State Hospital. He succeeds Dr. John I. Wiseman, who retired after serving in the post for the past seven years.

HAYWARD R. HAMRICK, M.D., of Philadelphia, has been appointed as a member of the board of trustees of

the Eastern Pennsylvania Psychiatric Institute. He will represent the Jefferson Medical College on the board, succeeding Mr. Robert P. Hooper, who has resigned.

FLOYD E. SHAFFER, M.D., who has been associated with the medical department of the Bethlehem Steel Company since 1919, was named medical director, September 6, to succeed the late Dr. Loyal A. Shoudy. Dr. Shaffer had been serving as Dr. Shoudy's assistant for several years.

GARFIELD G. DUNCAN, M.D., director of the medical divisions of Pennsylvania Hospital and the Benjamin Franklin Clinic, Philadelphia, left for Japan in September to make a six-week tour of medical installations in the Far East. As an expert consultant in internal medicine to the Surgeon-General of the U. S. Army, Dr. Duncan will evaluate and make recommendations concerning the installations in the Far East command area.

WILLIAM A. JACQUES, M.D., has been appointed chief medical officer of the Philadelphia Veterans Administration regional office. He succeeds Dr. Charles A. Gibbons, who was appointed chief of professional services at the new Wilkes-Barre VA Hospital. Dr. Jacques has been associated with the VA since 1946. Since May 1, 1949, he served as national supervisor of auxiliary VA medical services, with headquarters in Washington, D. C.

THE COUNCIL ON GRADUATE MEDICAL EDUCATION and the New York State chapter of the American College of Chest Physicians are sponsoring a graduate course in diseases of the chest to be held in the Hotel New Yorker, New York City, Nov. 13-18, 1950. Instructors will be members of the staffs of New York City medical schools and hospitals. There will be a morning and an afternoon session each day, Monday through Friday, with evening sessions Tuesday and Wednesday, and a morning session on Saturday, the last day. The subscription fee is \$50 for the entire course. A detailed program may be secured by writing the American College of Chest Physicians, 500 N. Dearborn St., Chicago 10, Ill.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ Desiderio Roman, Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1893; aged 80; died Sept. 7, 1950. Dr. Roman, a brother of the late President Victor Manuel Roman y Reyes of Nicaragua, who died last May, was associated for many

years with Hahnemann Hospital as senior surgeon and professor of clinical surgery. He served also as surgeon-in-chief and head of the surgical department of St. Luke's and Children's Medical Center from 1906 until the time of his death. A world citizen in the best sense of the term, he labored indefatigably to promote better relations between his native Nicaragua and other Central American countries and the United States, of which he was a naturalized citizen. He was familiar also with the great cultural centers of Europe, having done postgraduate medical work at the Universities of Heidelberg and Berlin, as well as in Vienna, Prague, Berne, Paris, and London. He paid annual visits to those centers from 1910 to 1940 excepting the years in which we were engaged in war. Dr. Roman was a past president of the United States Chapter of the International College of Surgeons, and from 1943 to 1945 was head of the college itself; twice president of the Philadelphia County Medical Society; a president of the Philadelphia chapter of the Pan American Medical Association; a founder and Fellow of the American Board of Surgery; and a member of the Board of Governors of the American College of Surgeons. He is survived by his widow and a nephew, Desiderio A. Roman, M.D., of Philadelphia, son of the late Nicaraguan president.

○ **John B. Carrell**, Hathboro; Jefferson Medical College of Philadelphia, 1876; aged 99; died Sept. 20, 1950, in Abington Memorial Hospital. He was formerly editor of *The Bucks County Medical Monthly*. For many years after he gave up most of his medical practice in 1924, he worked on a medical history of Bucks County. He collected material, including photographs, for more than 300 biographies of members of the county medical society. On the occasion of the celebration in November, 1948, of the centenary of his county medical society, Dr. Carrell was in rare form and played his part in the formal program. He was a member of the Montgomery County Historical Society and of the Sons of the American Revolution. A brother and an adopted daughter are the only survivors.

○ **Charles S. Caldwell**, Pittsburgh; Hahnemann Medical College and Hospital of Philadelphia, 1903; aged 69; died Sept. 2, 1950. Dr. Caldwell became chief of the department of radiology at Shadyside Hospital in 1925 and served until 1949, when he retired. For 20 years he was school physician and a school director of Swissvale. He was a Fellow of the American College of Radiology and a member of the Radiological Society of North America, Inc., the Pennsylvania Radiological Society, and the Pittsburgh Roentgen Society. During World War I, he served overseas as a captain in the Army Medical Corps. Surviving are his widow, two daughters, and five brothers.

○ **Lyman D. Heim**, Schuylkill Haven; Jefferson Medical College of Philadelphia, 1903; aged 73; died Sept. 20, 1950. Dr. Heim was one of the founders and chief of staff of the A. C. Milliken Hospital in Pottsville. He retired last year after having practiced almost 50 years. He was a past president of the Schuylkill County Medical Society, president of the Schuylkill Haven Board of Health for 25 years, a member of the borough school board, as well as physician for the

Schuylkill County Institutional District. Surviving are his widow, a daughter, and a son, Dr. Hugh W. Heim, chief surgeon at the Nanticoke State Hospital, and a brother.

Ralph W. Plummer, Philadelphia; Rush Medical College, Chicago, 1897; aged 75; died Aug. 28, 1950, at Hahnemann Hospital where he was medical director until he retired in 1948. He was formerly medical director at Graduate Hospital. Dr. Plummer, who had held the rank of captain in the Navy for more than 25 years before going to Philadelphia, had been fleet surgeon in both the Atlantic and Pacific. During World War I, he had charge of medical stores for the overseas forces. He was a Fellow of the American College of Surgeons.

○ **John E. Fretz**, Easton; University of Pennsylvania School of Medicine, 1897; aged 76; died Aug. 31, 1950, at his home after a long illness. Dr. Fretz was vice-president and on the executive committee of the Pennsylvania Tuberculosis and Health Society, and was a Fellow of the American College of Physicians. He was active in religious and civic circles. In 1947 he was honored by the State Medical Society on completion of 50 years of medical practice. His widow, a daughter, and a sister survive.

○ **Loyal A. Shoudy**, Bethlehem; University of Pennsylvania School of Medicine, 1909; aged 70; died Aug. 30, 1950, in St. Luke's Hospital where he had been a patient since May. Dr. Shoudy was chief of medical service for the Bethlehem Steel Company, and had served two terms as president of the American Association of Industrial Physicians and was a director of the association for 30 years. He was a Fellow of the American College of Surgeons. A sister survives.

○ **William J. Sterrett**, Beaver Falls; University of Pittsburgh School of Medicine, 1901; aged 76; died Sept. 5, 1950, at Allegheny General Hospital, Pittsburgh, where he had been a radiologist for more than 30 years. Dr. Sterrett was a member of the Radiological Society of North America, Inc. He was a veteran of the Spanish-American War, the Mexican border campaign, and World War I. Surviving are his widow, two sons, a daughter, and two brothers.

○ **Merle R. Hoon**, Pittsburgh; University of Pennsylvania School of Medicine, 1918; aged 58; died of a heart attack in his office Aug. 31, 1950. Dr. Hoon was on the staff at Presbyterian and the Woman's Hospitals in Pittsburgh, Suburban Valley and Ohio Valley Hospitals, and a consultant at others. He was a member of the Pittsburgh Surgical Society and a Fellow of the American College of Surgeons. Surviving are his widow, one son, two daughters, and a brother.

William R. Bready, Philadelphia; University of Pennsylvania School of Medicine, 1902; aged 74; died Sept. 17, 1950, after a long illness. He was secretary-treasurer of the Northern Dispensary, Temple Hospital, a member of the staff of Germantown Hospital, and an inspector for the Philadelphia Department of Public Health. During World War I, he was a captain in the Army Medical Corps. Two sons survive.

○ **Caleb McCune**, McKeesport; University of Pennsylvania School of Medicine, 1907; aged 70; died Aug.

29, 1950, following a heart attack. From 1918 to 1935 Dr. McCune served as senior obstetrician at McKeesport Hospital. A heart attack brought about his retirement from that post. He was McKeesport school physician the past three years. Three daughters and a brother survive.

○ Edward K. Smith, Lancaster; University of Pennsylvania School of Medicine, 1918; aged 55; died Sept. 12, 1950, of a cerebral hemorrhage. Dr. Smith served for 12 years as physician for the Lancaster city schools and was a staff member of Lancaster General, St. Joseph's, and Elizabethtown Crippled Children's Hospitals and Rossmere Sanatorium. He was a member of the American Academy of Pediatrics. Surviving are his widow, a sister, and three brothers.

○ William G. Moyer, Quakertown; Hahnemann Medical College and Hospital of Philadelphia, 1905; aged 67; died Sept. 8, 1950, following a year's illness. Dr. Moyer was on the staff of Grand View Hospital. He was a veteran of World War I. Surviving are his widow, three sons, one of whom, Dr. Stanley M. Moyer, also practices medicine in Quakertown, a daughter, and a sister.

○ Joseph L. Conrad, McKeesport; Hahnemann Medical College and Hospital of Philadelphia, 1906; aged 70; died Aug. 30, 1950, of a heart attack—minutes after he had addressed the McKeesport Y.M.C.A. on the relation between actual and imaginary illnesses. He is survived by his widow, two sons, and a daughter.

Clyde E. Kelly, Vandergrift; University of Maryland School of Medicine, Baltimore, 1929; aged 49; died suddenly Aug. 30, 1950, while vacationing in Can-

ada. He had been suffering from a heart ailment. A sister survives him.

○ Raymond H. Stutzman, Tower City; Maryland Medical College, Baltimore, 1912; aged 65; died Sept. 25, 1950, in Warne Hospital, Pottsville. He is survived by his widow, three sons, and two brothers.

Jack B. Tinsley, Roseto; Jefferson Medical College of Philadelphia, 1949; aged 28; died Sept. 6, 1950. He served in the U. S. Army during World War II. His wife and two children survive.

○ Thomas O. Nock, Philadelphia; University of Pennsylvania School of Medicine, 1886; aged 87; died Aug. 31, 1950, after a long illness. He is survived by two daughters.

THE STORY BEHIND THE WORD

Some Interesting Origins of Medical Terms

Impetigo.—This common skin disease is so called because of its contagious nature. It is derived from the Latin word "impeto," I attack. It is mentioned by Celsus in his book *De Medicina* written about A. D. 30.

Bougies.—These flexible instruments for urethral exploration, which are now usually made of woven silk and varnished, were at first made of wax or elastic gum. Medically we borrowed the term from France where the word "bougie" signified a wax candle and was so named from the town of Bougie in Algeria.—HARRY WAIN, M.D., *The Ohio State Medical Journal*.

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WHERE DOES A.P.H.A. STAND?

Recently Dr. Dean A. Clark, chairman of the Subcommittee on Medical Care of the American Public Health Association, sent us a letter and a booklet entitled "The Quality of Medical Care in a National Health Program," asking us to review the book and comment upon it.

Well, we read the book and carefully reviewed it, with marginal notes mostly ending in question marks.

Several observations seem pertinent. One revolves around the fact that this statement from an official A.P.H.A. committee is almost painful in its similarity to Oscar Ewing's book (published and distributed at taxpayers' expense) called "The Nation's Health." Dr. Clark's committee is almost lyrical in its praise of an "integrated system of medicine" involving a network between "outlying rural health centers, small community hospitals, affiliated with larger district hospitals—all converging on the teaching institutions of metropolitan centers." All this corresponds most accurately with the portrayal of such an organization on page 175 of Ewing's book.

Many details of organization and administration are discussed and recommended, including approving interest in the H.I.P. plan of Greater New York. Matters of finance include recommendations of "modification of the traditional fee-for-service method," obviously outmoded in the minds of the committeemen, in favor of such "approved" methods as payment by capitation fee. The "good" from this program of the A.P.H.A. (Ewing?) is made feasible only by "removal of financial barriers" between the patient and doctor! All can be accomplished by "adequate and secure" financing through "social insurance supplement by general taxation, or general taxation alone." The administrative system can "take advantage of the now considerable experience accumulated in this and other countries." (!!)

The whole booklet is so plainly a presentation in detail by an A.P.H.A. Committee of the Ewing program that one wonders about the possibilities of a common author. Sure enough—included among the members of the committee who but Isadore Falk appears!

Enough of the details. The real question which recurs again and again is our concern about the position of the whole American Public Health Association. Obviously one of its committees is speaking out for the Truman-Ewing administration plan for compulsory health insurance which is opposed by 90 per cent of organized medicine. Must we then regard public health organizations and their officials as enemies, rather than as the friends of other years? If the committee does not truly represent the thinking of the membership of the A.P.H.A., is there evidence of such opinion from that membership? Until such evidence is forthcoming, should organized medicine continue to support requests for aid and collaboration from the so-called public health people?

The most convincing answer to these questions would be a return by the A.P.H.A. to concentration upon matters truly related to preventive medicine and real public health and complete severance of its activities from matters of general medical care and from politic-economic interests so fascinating to so many students of

Bismarckian and, now, English, state-socialism. All too often lately we find public health officials and public health organizations disregarding their very real responsibilities toward public health and find some medical schools minimizing their primary factor of teaching young men to be doctors, both in favor of an obsessive interest in foreign socialistic experiments.

Surely our whole system of medical care and public health will improve, expand, and be constantly strengthened if medicine and all its ancient allies will just stick each to its own business along the traditional and time-proven American plan of voluntary, competitive endeavor and free enterprise.—*Rocky Mountain Medical Journal*, July, 1950.

CLASSIFIED ADVERTISEMENTS

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Florida Vacation.—Have fun and a thrilling new experience. Enjoy Florida in a big deluxe trailer. Completely furnished. Contact A. S. STEVENSON, M.D., 503 Westminster Ave., Orlando, Fla.

For Rent.—Doctor's office—four rooms and lavatory, first floor. Restricted neighborhood; 28,000 population. Two general hospitals. Contact MRS. BARTON THOMAS, 810 High St., Pottstown, Pa.

For Sale.—Doctor's residence with fully equipped offices at 612 West Market St., Pottsville, Pa. For sale because of death. Well-established ophthalmologic practice. Excellent opportunity. Write MR. F. C. MENGEL, 38 St. John St., Schuylkill Haven, Pa.

Residency Available.—Anesthesiology residency starting January 1, Board approved training. All phases of clinical anesthesiology; only graduates of approved medical schools accepted. Apply to ANTHONY T. ROSE, M.D., Director of Anesthesiology, Mt. Sinai Hospital, Philadelphia 47, Pa.

Opportunities for Physicians.—Are you interested in a position in one of our county or district health departments? Salary \$5,600 to \$7,200 with \$70 a month travel allowance. Public health scholarships available with liberal stipends. Men and women physicians eligible. Write FELIX J. UNDERWOOD, M.D., Mississippi State Board of Health, Jackson, Miss.

Wanted.—General practitioner for assistant to well-established and older Fellow of the American College of Surgeons. Married man desired. Good hospital facilities. Salary for first six months, then percentage. Apartment available in suburban area of twin cities. Great future. Minnesota license or national boards necessary. Write Dept. 207, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Physician for industrial borough of 3000 population in south-central Pennsylvania rich farming area. Only three active physicians trying to serve the community. Dislike to retire on account of ill health, leaving these people in need of several additional physicians. Nothing to sell except modern two and one-half story two-family apartment house, well located in business section. First-floor apartment consists of seven rooms, two baths, shower, and two-room office suite. Second floor consists of six rooms and bath. Bryant natural gas furnace, hot water heating system thermostatically controlled. Office equipment optional. Wonderful opportunity. Must be seen to be appreciated. Write Dept. 218, PENNSYLVANIA MEDICAL JOURNAL.

BOOK REVIEWS

The Cytologic Diagnosis of Cancer. By the staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital. A gynecologic service affiliated with the Massachusetts General Hospital, Boston, Mass. The Department of Gynecology, Harvard Medical School. Published under the sponsorship of the American Cancer Society. Philadelphia and London: W. B. Saunders Company, 1950. Price, \$6.50.

Here is a book which presents the result of six years' experience in establishing the value of the cytologic technique in the determination of cancer of the cervix and other organs. This work was done in the Vincent Memorial Laboratory and was started in 1942. In all, the book represents a study made on almost 8000 cases by vaginal smears, 450 cases by smears of sputum and bronchial aspirations, 400 cases by smears of urine sediment, 400 cases by smears of gastric secretion, and 250 cases by examination of sediment of serous fluid. The book of 230 pages contains 153 illustrations of the material pertaining to this study. It is clearly presented beginning with a histologic section of the tissue under discussion. Each section is followed by a black and white photomicrograph and a colored drawing of a field of cells derived from that particular epithelium. A separate chapter is devoted to the technique of preparing the different secretions for study and there is an exhaustive and comprehensive bibliography. In all, this is a delightful addition to any clinician's library. It places at his disposal the very latest knowledge pertaining to carcinoma cytology. This reviewer agrees wholeheartedly that cancer can be attacked and conquered more efficiently if encountered in its preclinical stage. For this reason, any aid to facilitate such early discovery is a valuable adjunct indeed. The staff of the Vincent Memorial Laboratory is to be congratulated for having produced so valuable a volume.

Progress in Clinical Endocrinology. Edited by Samuel Soskin, M.D., Director, Medical Research Institute, Michael Reese Hospital, Chicago, Ill.; Dean, Michael Reese Hospital Postgraduate School; Professorial Lecturer in Physiology, University of Chicago. New York: Grune & Stratton, 1950. Price, \$10.00.

An authoritative appraisal of progress in endocrinology is a welcome addition to the increasing accumulation of facts and near facts in this expanding and rapidly advancing field.

Seventy-nine articles by 92 contributors survey the field reviewing current and timely topics in endocrinology. For the most part each treatise is highly technical, deals with a specific problem or phase of a general subject, and is written in telegraphic style. However, an ample bibliography has been provided with each article for the reader who desires more detailed information or relevant reading.

Of interest is the awareness that in some instances conflicting opinions and policies have been editorially omitted. A prime example is the group of reports on diabetes mellitus from the laboratories of the "free dieters" with the exception of an article on insulin mixtures. This is also evident by the review of laboratory procedures designed to facilitate an evaluation of the adrenal reserve when the discussion is limited to one test and its modifications, which in many laboratories is still a non-practical tool. The water excretion test, with generally accepted minimal limitations, is much easier and inexpensive and doesn't require a semi-skilled technician. This appraisal is not meant to detract from the information and contribution the ACTH test does make to such an evaluation.

The review of ACTH and Compound E is comparatively incomplete and brief, particularly in view of the current enthusiasm for their use in investigating so many varied situations. One explanation for this is the time limits and incompleteness of the reports at the time this book went to press.

Contrary to the reviewers' report on the fascinating tumor, pheochromocytoma, a case is on record with a false positive test with benzodioxan.¹

To discuss each topic is prohibitive. This book is filled with information, and I am sure that the graduate student, the internist, and the endocrinologist will find it a ready source of succinct, authoritative, stimulating, and controversial material.

Clinical Nutrition. Edited by Norman Jolliffe, M.D., F. F. Tisdall, M.D., and Paul R. Cannon, M.D., for the Food and Nutrition Board of the National Research Council. With 78 tables and 127 illustrations, 61 in full color. New York: Paul B. Hoeber, Inc., Medical

1. TALIAFERRO, ISABEL, ADAMS, RAYMOND A., and HAAG, H. B.: Benzodioxan Test: Fall in Blood Pressure Following Its Use in a Case of Renal Hypertension, *J. A. M. A.*, 140: 1271-1273, Aug. 30, 1949.

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Book Department of Harper & Brothers, 1950. Price, \$12.00.

The past 25 years have seen the coming of age of our understanding of nutrition in health and disease. The practitioner has always been familiar with the severe (but, fortunately, rather rare) manifestations of nutritional deficiencies—starvation edema, rickets, scurvy, pellagra, etc. But, for most of us, the recognition of the early clinical manifestations of malnutrition remains a difficult diagnostic problem. Correction of the deficiency is, in most cases, not difficult if the diagnosis is correct. Hence it is of increasing importance to recognize not only the primary deficiency but also the “conditioned” deficiency, that is, the secondary effects of illness resulting in nutritional inadequacy.

To help us to this end, the Food and Nutrition Board of the National Research Council has had a handbook, *Clinical Nutrition*, prepared under the editorship of Drs. Jolliffe, Tisdall, and Cannon.

The editors have fully realized the aim of the board in preparing a thorough and readable clinical presentation of the material. The 36 men writing for the book represent the ablest of our investigators and teachers among American nutritional experts. The book is divided into three major sections.

Part I deals with the diagnosis of nutritional deficiency. The illustrations of the anatomic and radiologic manifestations of nutritional deficiency are admirable. More than 60 of these illustrations are in full color and offer practical help in the recognition of the clinical signs of deficiency states. This section also contains an important consideration of the dietary and medical history in nutritional diagnosis and method of quick evaluation of the dietary pattern that will be helpful in clinical practice.

Part II deals in detail with the various types of nutritional deficiency. Here are chapters on protein and carbohydrate deficiencies, mineral deficiencies, and vitamin deficiencies. The emphasis again is on clinical recognition and treatment.

Part III is devoted to nutritional therapy and prophylaxis. There is a complete consideration of the relatively new field of dietotherapy, including an extensive presentation of actual dietary outlines for use in various diseases. This section will be invaluable to the practicing physician. Part III also includes a complete evaluation of diets in cardiac and hypertensive disease, such as the low sodium diet, the acid-ash diet, and the Kempner diet. Diets for patients with cholecystic disease, for patients who must be fed orally, intravenously, or by tube, for elderly patients, and for patients with all the various diseases in the management of which diet is important are also presented in this section and discussed and evaluated in detail.

The chapter on obesity, stressing the importance of excess caloric intake in the development of this state, gives the reader a well-thought-out analysis of the problems encountered in the management of overweight patients.

Two other important parts of this section are the consideration of the public health aspects of nutrition and the excellent appendix. In the appendix the editors have assembled for ready reference representative diets for children, old people, and pregnant women. The diets

of various national and regional groups are also given, as is a table of food values.

These reviewers would like to congratulate the editors for the careful planning and uniform presentation that has resulted in so outstanding a volume on nutrition. It is recommended as a “must” book for every conscientious practitioner of medicine.

A Textbook of X-Ray Diagnosis. By British authors in four volumes. Second edition. Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director, X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Director, X-Ray Department, Westminster Hospital; Radiologist, Royal Chest Hospital, London. Volume IV. 592 pages with 553 illustrations. Philadelphia and London: W. B. Saunders Company, 1950. Price, \$15.00.

This is the second edition of a work which first appeared ten years ago. One of the original editors, Dr. Edward W. Twining, died since the publication of the first edition. This second edition has been greatly enlarged so that four volumes rather than three have been published. The editors have incorporated all the new concepts of diagnostic radiology developed since the advent of the first edition. They have attempted to make this edition as near up-to-date as a textbook can be.

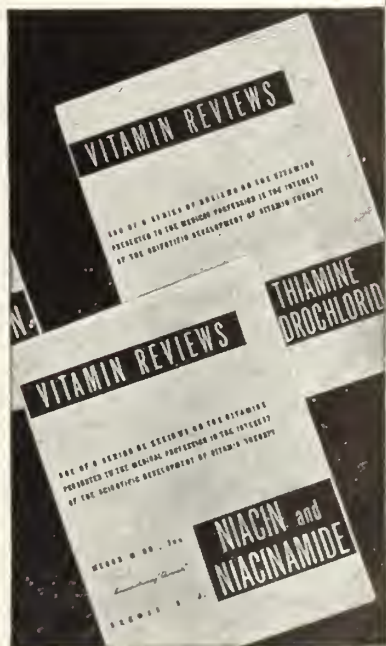
In the fourth volume, diseases of the bones, joints, and soft tissues are described. This book is further subdivided into the following categories: the normal bones and joints of the extremities, the normal spine and pelvis, the general pathology of bone, congenital deformities of bones and joints, traumatic lesions of bones and joints, inflammatory diseases of bones and joints, static and paralytic lesions, constitutional diseases of bones and joints, tumors and cysts, and the soft tissues. In this edition, there has been a thorough overhauling of the subject matter and a great deal of new material has been added. The material is well written and profusely illustrated with radiographs, photomicrographs, and drawings. The radiographic illustrations deserve special comment because of their excellent quality. This volume is highly recommended as a reference book for diseases of the bones, joints, and soft tissues.

Essentials of Obstetrical and Gynecological Pathology. By Robert L. Faulkner, M.D., F.A.C.S., Assistant Professor of Gynecology, the Western Reserve Medical School; Associate Gynecologist, University Hospitals of Cleveland, Ohio; and Marion Douglass, M.D., formerly Assistant Professor of Gynecology, the Western Reserve Medical School. With 300 illustrations, including 3 color plates. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$8.75.

This is the second edition of an original work of great merit. Since more and more hospitals are establishing departments of obstetrics and gynecology, special pathology has become of continually increasing importance. The average obstetrician or gynecologist encounters great trouble in finding pathologic fundamentals and relationships that are specific for his specialty. The author has admirably satisfied this need. In the early chapters the technical handling of specimens taken at operation is thoroughly discussed. This is followed by the pathology of the various tissues and glands

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characteristic of the female reproductive organs. The special problems of the pathology of all the structures pertaining to obstetrics and gynecology are found in the next eight chapters. Finally, a chapter devoted to pathologies of pregnancy completes this excellent monograph. The volume is made up of 357 pages of delightfully legible print accentuated by more than 300 clear illustrations. The armamentarium of any obstetrician or gynecologist would be markedly enhanced by the addition of this volume. Your reviewer warmly recommends it.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Steroid Hormones and Tumors. Tumorigenic and antitumorigenic actions of steroid hormones and the steroid homeostasis. Experimental aspects. By Alexander Lipschutz, M.D., formerly Professor of Physiology, Hon. M. Roy. Soc. Med. (Endocrinol.); Charles M. Mayer Cancer Award, National Science Fund of the National Academy of Sciences, 1944; Director of the Department of Experimental Medicine, National Health Service of Chile. Baltimore: The Williams & Wilkins Company, 1950. Price, \$6.00.

The Antihistamines. Their Clinical Application. By Samuel M. Feinberg, M.D., Associate Professor of Medicine, Chief of Division of Allergy, and Director of Allergy Research Laboratory; Saul Malkiel, Ph.D., M.D., Assistant Professor of Medicine, Director of Research, Allergy Research Laboratory; Alan R. Feinberg, M.D., Clinical Assistant in Medicine, Attending Physician in Allergy Clinic, Northwestern University Medical School. Chicago: The Year Book Publishers, Inc., 1950. Price, \$4.00.

Cerebral Palsy. By John F. Pohl, M.D., Orthopedic Surgeon, Michael Dowling School for Crippled Children, Minneapolis, Minn. St. Paul, Minn.: Bruce Publishing Company, 1950. Price, \$5.00.

Non-gonococcal Urethritis. Including the genital manifestations of local and systemic diseases and infestations of the urinary tract with protozoa, metazoa, and fungi. By A. H. Harkness, M.R.C.S., L.R.C.P., Joint Director of the Endell Street Clinic, St. Peter's and St. Paul's Hospitals (Institute of Urology); Lecturer to the Institute of Urology; Consultant in Venereal Diseases to St. Charles' Hospital; the Civil Consultant in Venereal Diseases to the Royal Navy; Physician to the London Skin Hospital; Vice-President (Past President) of the British Society for the Study of Venereal Diseases. 167 illustrations, 73 in full color. Baltimore: The Williams & Wilkins Company, 1950.

The Management of Obstetric Difficulties. By Paul Titus, M.D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Shadyside Hospital, Pittsburgh; Secretary of the American Board of

Obstetrics and Gynecology; Member, Reserve Consultants' Advisory Board, Bureau of Medicine and Surgery, United States Navy (Captain, MC, USNR). With 446 illustrations and 9 color plates. Fourth edition. St. Louis: The C. V. Mosby Company, 1950. Price, \$14.00.

Doctor Come Quickly. By Frank J. Clancy, M.D. Seattle: Superior Publishing Company, 1950. Price, \$2.95.

Freud: Dictionary of Psychoanalysis. Edited by Nandor Fodor, Associate of the Association for the Advancement of Psychotherapy, and Frank Gaynor, co-author of the *Dictionary of Industrial Psychology*. With a preface by Theodor Reik, author of *Listening with the Third Ear*. New York: Philosophical Library, 1950. Price, \$3.75.

Immortal Magyar. Semmelweis, Conqueror of Childbed Fever. By Frank G. Slaughter, M.D. New York: Henry Schuman, 1950. Price, \$3.50.

Textbook of Abnormal Psychology. By Roy M. Dorcus, Professor of Psychology, Division Dean of Life Sciences, University of California; Professor of Psychology, University of California Medical School, Los Angeles; and G. Wilson Shaffer, Dean of the University, Professor of Psychology, Director of the Psychological Clinic, Johns Hopkins University; Chief Psychologist, Sheppard-Enoch Pratt Hospital, Towson, Md. Fourth edition. Baltimore: The Williams & Wilkins Company, 1950. Price, \$5.00.

Eyes and Industry. Formerly *Industrial Ophthalmology*. By Hedwig S. Kuhn, M.D., Industrial Ophthalmologist, Hammond, Ind. With 151 text illustrations including three color plates. Second edition. St. Louis: The C. V. Mosby Company, 1950. Price, \$8.50.

Pathologic Physiology: Mechanisms of Disease. Edited by William A. Sodeman, M.D., F.A.C.P., the William Henderson Professor of the Prevention of Tropical and Semi-tropical Diseases, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana; Consultant in Medicine, U. S. Marine Hospital at New Orleans. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$11.50.

An Atlas of Human Anatomy. By Barry J. Anson, Ph.D., Professor of Anatomy, Northwestern University Medical School. Philadelphia: W. B. Saunders Company, 1950. Price, \$11.50.

Sir William Osler. Aphorisms from his bedside teachings and writings. Collected by Robert Bennett Bean, M.D. (1874-1944). Edited by William Bennett Bean, M.D. New York: Henry Schuman, Inc., 1950. Price, \$2.50.

The Prostate Gland. By Herbert R. Kenyon, M.D., Associate Clinical Professor, Department of Urology, New York University, Bellevue Medical Center. New York: Random House, 1950. Price, \$2.95.

Santa Claus, M.D. By W. W. Bauer, M.D. Indianapolis, Ind.: The Bobbs-Merrill Company, Inc., 1950. Price, \$2.75.

Williams' Obstetrics. By Nicholson J. Eastman, Professor of Obstetrics, Johns Hopkins University, and Obstetrician-in-Chief to the Johns Hopkins Hospital. Tenth edition. New York: Appleton-Century-Crofts, Inc., 1950. Price, \$12.50.

Vocational Rehabilitation of Psychiatric Patients. By Thomas A. C. Rennie, M.D., Cornell University Medical College and the New York Hospital, Temple Burling, M.D., and Luther E. Woodward, Ph.D., Division on Rehabilitation, The National Committee for Mental Hygiene. New York: The Commonwealth Fund, 1950. Price, 75 cents.

Physician's Handbook. By Marcus A. Krupp, M.D., Assistant Clinical Professor of Medicine, Stanford University School of Medicine; Director of Clinical Pathology, Veterans Administration Hospital, San Francisco; Norman J. Sweet, M.D., Assistant Professor of Medicine, University of California School of Medicine, San Francisco; Ernest Jawetz, Ph.D., M.D., Associate Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco; and Charles D. Armstrong, M.D., Clinical Instructor in Medicine, Stanford University School of Medicine. Sixth edition. Palo Alto, Calif.: University Medical Publishers, 1950. Price, \$2.50.

The Truth About Your Eyes. By Derrick Vail, M.D. New York: Farrar, Straus and Company, 1950. Price, \$2.50.

Principles of Public Health Administration. By John J. Hanlon, M.S., M.D., M.P.H., Associate Professor of Public Health Practice, School of Public Health, University of Michigan, and Chief Medical Officer and Associate Chief of Party, Bolivia, The Institute of Inter-American Affairs. With 48 illustrations. St. Louis: The C. V. Mosby Company, 1950. Price, \$6.00.

PUBLIC HEALTH SCHOOL OPENS AT UNIVERSITY OF PITTSBURGH

The University of Pittsburgh's new Graduate School of Public Health opens its doors to students for the first time this fall, an event of signal importance to Pennsylvania. It means that this Commonwealth, long in need of a school for training and research in the broad field of public health, now has one of the finest institutions of this kind in the United States. Classes are scheduled to begin on Monday, Sept. 25, 1950.

Made possible by a gift of \$13,600,000 from the A. W. Mellon Educational and Charitable Trust, the school is part of the university's large medical center. It will award degrees of Doctor of Public Health and Master

of Public Health to physicians, nurses, sanitary engineers, dentists, bacteriologists, and others in allied fields.

In addition to providing opportunities for public training and research, the curriculum of the school, as now planned, offers special study and research in occupational and industrial health, and also in hospital administration.

A faculty of instructors comprising outstanding authorities in their several fields will conduct the courses for which an initial student body of 30 has enrolled. The dean of the school is Dr. Thomas Parran, former Surgeon General of the United States Public Health Service. . . .

Permanent Quarters Planned

The temporary location of the school is Pittsburgh's Municipal Hospital, a unit of the university's Medical Center. Space adequate for teaching and research has been converted for the school's use. The Mellon Trust has set aside \$5,000,000 of the total gift to construct permanent quarters for the school after it is accredited to grant graduate degrees in public health, and after its work has been tied in with the university medical science schools and Pittsburgh hospitals. . . .

A Public Health Seminar conducted two hours weekly throughout the school year by Dr. Parran and the faculty is among the courses of instruction required for all students. The aim of the seminars is to integrate the separate courses offered in the curriculum by showing their place in the central purpose of the school, viz., teaching and research directed toward the preservation and improvement of health which ideally is conceived to be "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.*" Other required courses for all students include Biostatistics, Epidemiology and Microbiology, and Public Health Practice. Dr. Norris W. Vaux, Secretary of Health, Commonwealth of Pennsylvania, has been appointed as one of the lecturers on Public Health Practice.

The Department of Occupational Health has a contract with the Atomic Energy Commission for basic physiologic studies of radiation, and a contract with the U. S. Army Chemical Center for research on new chemicals and their toxicity.

Fellowships Offered

The school has announced a number of fellowships for qualified medical men. One is offered by the International Division of the Rockefeller Foundation; two senior fellowships from the U. S. Atomic Energy Commission; and a fellowship in occupational health offered by the school itself. Stipends for fellowship students are at the rate of \$3,600 to \$5,000 per year plus tuition.

Basic community needs for medical and hospital services will be studied by the Department of Biostatistics for the National Securities Resources Board. . . .

There are ten similar graduate schools of public health in the United States and Canada. They are located at Harvard, Yale, Columbia, Johns Hopkins, the Universities of North Carolina, Michigan, Minnesota, California, and Toronto, and Tulane University, Louisiana.—J. M. T. in *Pennsylvania's Health*, July-September, 1950.

WRITTEN CONSENT PREFERABLE

Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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Every precaution has been taken to insure accuracy in these advertisements and in this index, but there is no guarantee against errors or omissions.

THE PUBLIC HEALTH LAW RESEARCH PROJECT OF THE UNIVERSITY OF PITTSBURGH

At the request of the health authorities of the City of Pittsburgh and the Commonwealth of Pennsylvania, the School of Law of the University of Pittsburgh has launched a significant legislative research and drafting project looking toward compilation and revision of laws in the field of public health. Begun last June, the Public Health Law Research Project has carried out intensive research in the ordinances, regulations, and state laws administered by Pittsburgh in the health field. It is presently completing one urgently needed segment of its work—the publication of a compilation of the ordinances, laws, and regulations presently in force in Pittsburgh.

This compilation will include, in addition to the text of the applicable legislation, comments by the editors concerning legislative history, judicial interpretation, and administrative practice and construction. The product of numerous interviews with public health officers and administrators in the city and state governments, the information concerning administrative practice will not only serve to provide valuable background knowledge of enforcement and procedure in the fields of municipal regulation of sanitation and disease control but will also form the basis of judgments with regard to the adequacy and effectiveness of particular legislative programs. Since the compilation will ultimately provide the text from which to work in preparing a model code of public health laws for the city, complete information as to the operations of the bureaus and divisions of the Department of Public Health, as well as other departments of the city government, was considered necessary.

The research methods adopted by those engaged in the project were predominantly determined by the nature and source of the materials with which they worked. Thus it was necessary to devote the first few months to the collection, copying, and analysis of city ordinances relating to health. Copies of the ordinances were borrowed from the files of the Pittsburgh Department of Public Health, or, in some cases, made from the ordinance books in the city clerk's office. A study of state legislation was then undertaken with particular attention to the relevant statutes governing municipal health powers, and to laws of general application enforced by state officers in particular fields, such as food and restaurant sanitation, that might limit or altogether supersede local regulations.

Consultation with administrative officials in the health field followed the assembling of materials. The operation of each ordinance and statute was checked in the interviews and a memorandum of each conference was prepared. On the basis of the knowledge gained from these conferences and an analysis of the state and local legislation, a series of questions of law involving conflicts or possible conflicts between state and municipal regulatory programs was prepared and submitted to the city solicitor for an opinion respecting the validity of the local ordinances. Further conferences on these questions were held with officials of the Department of Public Health and of the city solicitor's office.

Final preparation of the compilation of the city's

public health laws was then begun, and the contents checked by members of the law school faculty, the staff of the University's Institute of Local Government, officials of the Department of Public Health, and the city solicitor's office. Early publication is expected.

On completion of this phase of the work, the project will proceed with a similar analysis and compilation of state laws and regulations of general applicability throughout Pennsylvania. In order that the work of revision may be begun at the earliest time possible, it is planned to begin a revision of a small segment of the Pittsburgh health laws at the same time that the compilation of existing state public health legislation is under way. Upon completion of the compilation of the state materials, full-scale revision of the city's public health laws will be in progress. It is expected that a similar revision of the state health laws and regulations will be undertaken at a later date, and that such revision may be undertaken with active cooperation with the Law School of the University of Pennsylvania.

The drafting of the model health codes by the project will necessarily involve the cooperation of public health officials, consultants in particular fields of public health and local government, the Graduate School of Public Health, and the law school. For this purpose, it is planned to create small consultative technical committees to work on the revision of specific phases of public health legislation. In addition, advice on more general questions of policy will be sought from representatives of the city and state health departments as well as of various civic, labor, business, and professional groups. The changes agreed upon will then be fitted into a legislative pattern by the project.

This ambitious enterprise had its inception in part in the recommendations of separate survey reports on the public health activities of the City of Pittsburgh and the Commonwealth of Pennsylvania. Both reports, prepared by the United States Public Health Service and the American Public Health Association respectively, stressed the need of codification and revision of the mass of state and municipal public health legislation, much of it old and outmoded, presently on the statute books. In a greater part, however, the project owes its existence to the earnest desire of the University of Pittsburgh, its law school, and its dean, Charles B. Nutting, to develop in the law school the competence and the will to serve local government in the solution of its manifold problems. Coming at a time when the University was expanding with the creation of a new Graduate School of Public Health, the demand for the project could be realized by a peculiarly fortunate aggregate of facilities. The faculty of the public health school is able to lend its experience, technical knowledge, and research facilities; the University's Institute of Local Government provides its knowledge of municipal problems and their solution; and the school of law provides the legal training and research. Thus the project is realizing a dual purpose—it is meeting an urgent need of local government by its specific assignment in this work, and at the same time it is developing, by cooperative University endeavor, a professional competence to deal with the needs and objectives of local government that municipal and state resources would not ordinarily be able to provide.

The financial support for the work has come from the A. W. Mellon Educational and Charitable Trust, which is also responsible for the establishment of the University's new Graduate School of Public Health. The project is under the general supervision of Dean Nutting, who has had extensive experience in the field of public law and legislation. Professor Harold Gill Reuschlein, formerly Chief of the Office of Legislative Services, Headquarters, Army Air Force, who has made municipal problems one of his specialties, is its director. Robert C. Brown, also a professor in the school of law, who served as an adviser to the Indiana Gross Income Tax Division and who is presently an adviser to the Pennsylvania Joint State Government Commission, serves in a consultative capacity. The work of research, writing, and ultimate draftsmanship is in the hands of two research fellows, both recent graduates of the University of Pittsburgh School of Law, James C. Kuhn, Jr., former editor-in-chief of the *University of Pittsburgh Law Review* and law clerk to Judge Dithrich of the Superior Court of Pennsylvania,

and David Stahl, former case editor of the *Late Review* and an instructor in the University's political science department.

Public health laws suffer not only from indifferent draftsmanship, to which so many state and local laws are heir, but also from the fact that science has moved rapidly in the past 50 years. Laws often include the vestigial remains of the obsolete science; they are geared to the medical knowledge of 1900 or 1920 rather than that of 1950. Codification is no mere problem of ironing out verbal and legal inconsistencies. To create a code that will most effectively serve the present and the future requires the closest kind of collaboration among legal, administrative, and scientific personnel. It is hoped that at Pittsburgh, through the school of law, the school of public health, the Institute of Local Government, and the collaboration of city and state agencies, codes may be created that will be a major demonstration of the value of cooperation among the several professions and government officials.—*American Bar Association Journal*.

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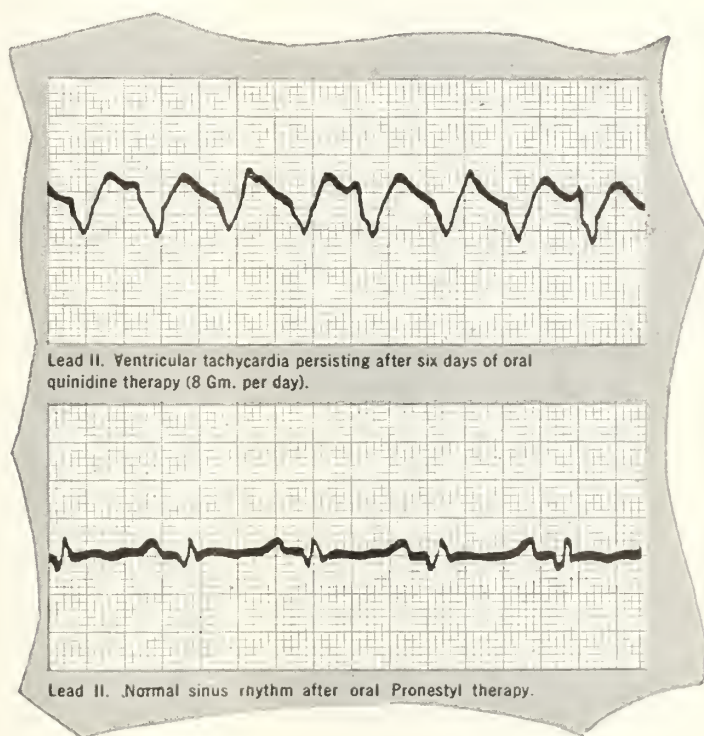
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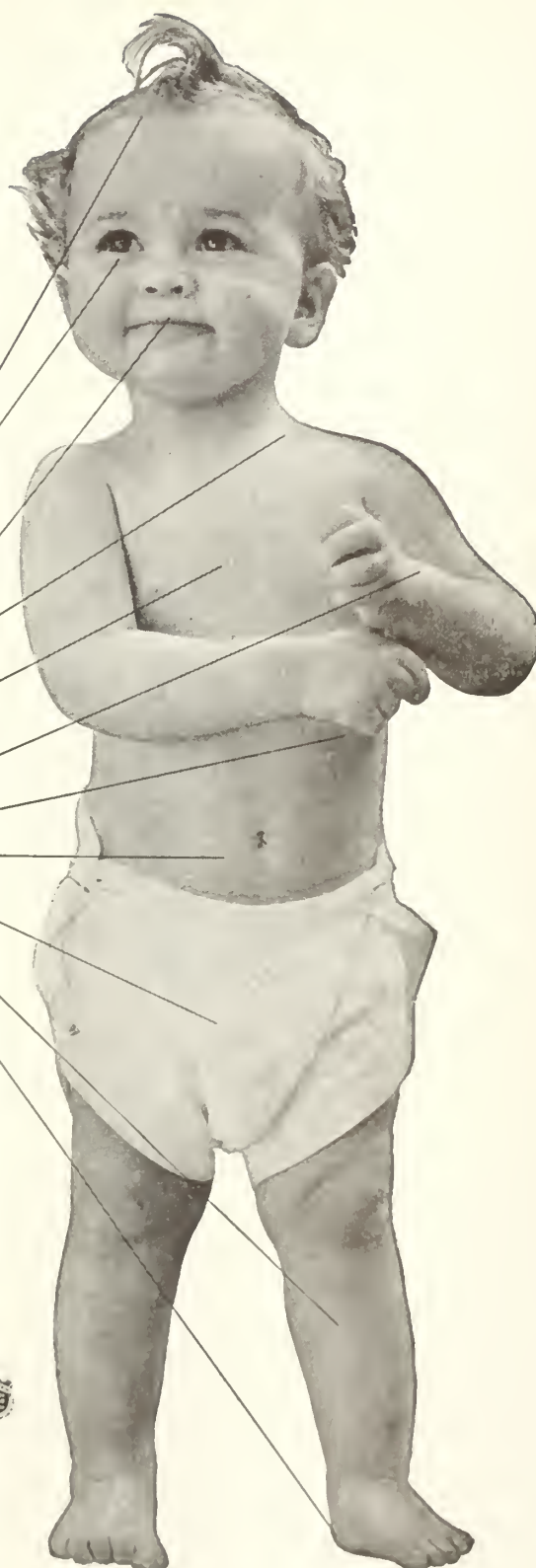
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Centre	John H. Light, Center Hall	Hiram T. Dale, State College	Monthly
Chester	Julius Margolis, Coatesville	Francis Jacobs, West Chester	Monthly
Clarion	Harrison M. Wellman, St. Petersburg	James M. Hess, Tyersburg	Quarterly
Clearfield	Frances DeBone Taylor, Philipsburg	George C. Covalla, Clearfield	Monthly
Clinton	Forney D. Winner, Lock Haven	David W. Thomas, Lock Haven	Monthly
Columbia	Joseph V. M. Ross, Berwick	Robert Klein, Bloomsburg	Monthly
Crawford	Samuel E. Hoke, Conneaut Lake	Robert G. Pett, Meadville	Monthly
Cumberland ...	William B. Turner, Carlisle	Richard R. Spahr, Mechanicsburg	Bimonthly
Dauphin	W. Paul Dailey, Harrisburg	Hamblen C. Eaton, Harrisburg	Monthly*
Delaware	Joseph F. Dougherty, Upper Darby	Walter E. Egbert, Chester	Monthly
Elk	Charles A. Hauber, St. Marys	Howard M. Keebler, St. Marys	Monthly*
Erie	John F. Hartman, Jr., Erie	Russell B. Roth, Erie	Monthly
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Huntingdon ...	John M. Keichline, Jr., Huntingdon	Robert H. Beck, Huntingdon	Monthly
Indiana	George W. Hanna, Homer City	Daniel H. Bee, Indiana	Monthly
Jefferson	Harry J. Robb, DuBois	E. Nicholas Sargent, Falls Creek	Monthly
Juniata	Penrose H. Shelley, Port Royal	Robert P. Banks, Mifflintown	Bimonthly
Lackawanna ..	Milton J. Goldstein, Scranton	Philip E. Sirgany, Scranton	Weekly
Lancaster	John D. Denney, Columbia	Charles P. Stahr, Lancaster	Monthly
Lawrence	Mary Baker Davis, New Castle	Wilbur E. Flannery, New Castle	Monthly
Lebanon	James T. Gallagher, Palmyra	J. DeWitt Kerr, Lebanon	Monthly*
Lehigh	Martin S. Kleckner, Allentown	Pauline K. Wenner, Allentown	Monthly
Luzerne	Louis W. Jones, Wilkes-Barre	Joseph W. Ehrhart, Forty-Fort	Semimonthly*
Lycoming	Louis E. Audet, Williamsport	Charles A. Lehman, Jr., Williamsport	Monthly
McKean	Sophonous A. McCutcheon, Bradford	Persis Straight Robbins, Bradford	Monthly
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Perry	Amos G. Kunkle, Liverpool	Frank A. Belmont, New Bloomfield	Bimonthly
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* Except July and August.

† Except June, July, and August.

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CRYSTALLINE

in Primary
Atypical
Pneumonia

The chemotherapy of primary atypical pneumonia has until recently been unsatisfactory. Aureomycin, which favorably influences the course even of severe cases, is now accepted as a treatment of choice in this disease.



Aureomycin

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Ophthalmic: Vials of 25 mg. with dropper;
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Aureomycin has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-acrogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, sub-acute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia and typhus.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

NOVEMBER, 1950

1145

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Please send me free booklet, "Symposium on Electrodesiccation and Bi-Active Coagulation."

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LETTERS

Educational Fund in Operation

GENTLEMEN:

Your society's check came safely and we have credited it to the account of _____ in the treasurer's office where it will be handled in accordance with your instructions. This is a very, very fine thing for the medical society to do. _____ is a worth-while young man and I am sure your assistance is thoroughly deserved.

CHARLES S. TIPPETTS, PH.D., *Headmaster,*
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Auxiliary Work Appreciated

GENTLEMEN:

We are indeed grateful to all the wonderful workers of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania for the marvelous work they have done so far this year in the humanitarian effort of helping those whose need is so great.

On behalf of the committee, may I express sincere thanks and appreciation.

The distress calls continue to come in far in excess of our ability to fill them all. It is with this thought in mind that I am again writing to you, with the hope that you will find it possible to continue sending medical and surgical supplies as they become available. The need for this today is greater than ever before. Your help at this time is most important.

May we count again on the efforts of the Auxiliary to help carry on this good work?

MRS. OLIVER P. J. CORWIN, *Executive Director,*
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Veterans Loan Fund MSSP

GENTLEMEN:

I enclose a check for \$500, payment in full to the Veterans Loan Fund MSSP of the loan made to me in September, 1947, which was to be repaid within three years without interest. I desire to express my appreciation of this loan and the belief that it accomplished or helped to accomplish its purpose in aiding me to return from military medical service to civilian life.

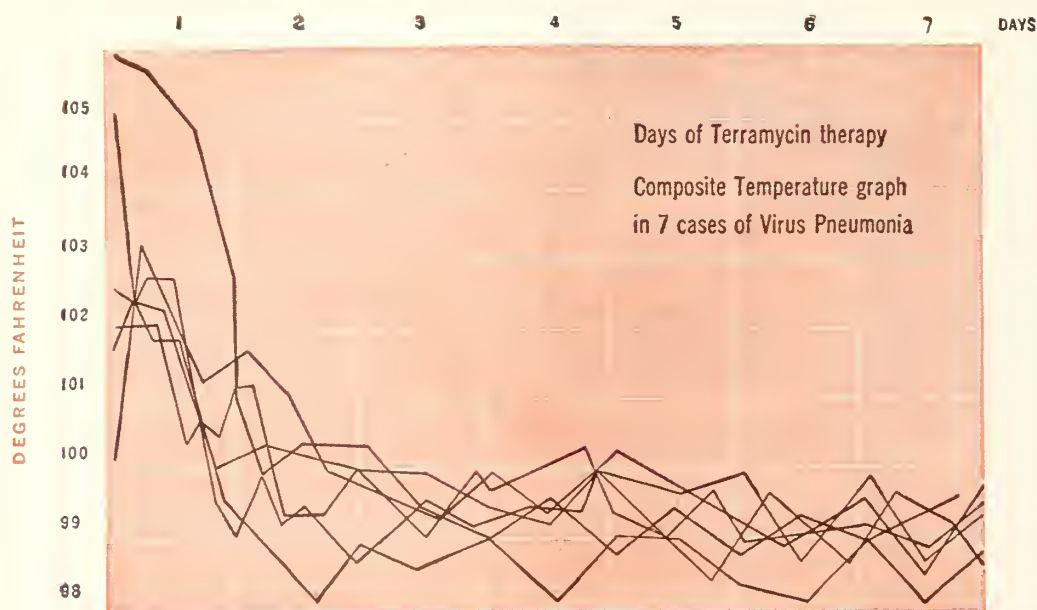
Yours truly,
_____, M.D.

GENTLEMEN:

I wish to express my thanks for the aid received from the Veterans Loan Fund MSSP, which I'm here-with repaying in full.

Sincerely,
_____, M.D.

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CRYSTALLINE
Terra

"Prompt fall in temperature occurred in every patient within thirty-six hours after the first dose of terramycin, and in no case was there a febrile relapse."

"Demonstrable clinical improvement was usually evident within a few hours after institution of therapy."

Melcher, G. W.; Gibson, C. D.; Rose, H. M., and Kneeland, Y.: J. A. M. A. 143:1303 (Aug. 12) 1950

Antibiotic Division

Pfizer

"Excellent" and "prompt" response

"The response to terramycin therapy was considered excellent in every case, and there were no cases in which treatment failed."

*Melcher, G. W.; Gibson, C. D.; Rose, H. M., and
Kneeland, Y.: J. A. M. A. 143:1303 (Aug. 12) 1950.*

Dosage: On the basis of findings obtained in over 150 leading medical research centers, 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for most acute infections.

Supplied: 250 mg. capsules, bottles of 16 and 100;
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50 mg. capsules, bottles of 25 and 100.

mycin

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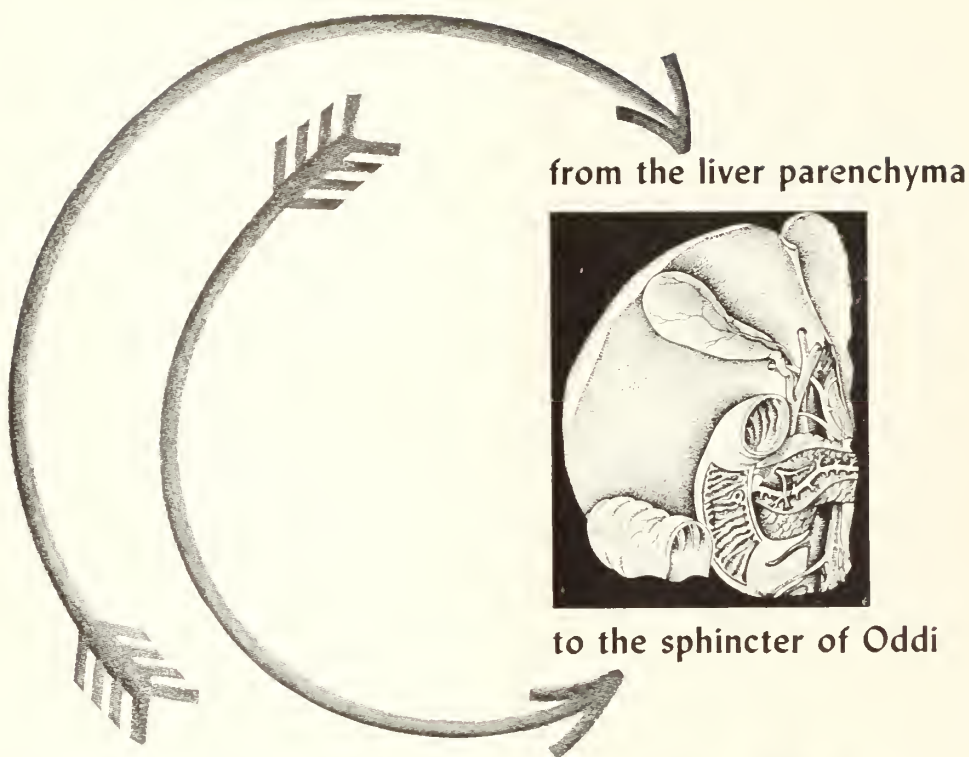
*Terramycin may be highly effective
even when other antibiotics fail.¹*

*Terramycin may be well tolerated
even when other antibiotics are not.²*

1. Blake, F. G.; Friou, G. J., and Wagner, R. R.; *Yale J. Biol. and Med.* 22:495 (July) 1950.

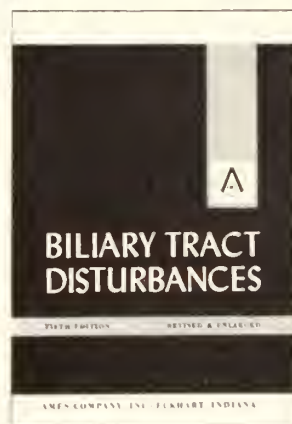
2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.; *Proc. Staff Meet. Mayo Clin.* 25:183 (Apr. 12) 1950.

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That a nutritious breakfast providing generous amounts of high quality protein prevents late morning hypoglycemia has been amply demonstrated. As shown by Thorn and co-workers,¹ and later confirmed by Orent-Keiles,² "... breakfast high in protein and low in fat and carbohydrate was followed by an improved sense of well-being and no symptoms of hypoglycemia."

Meat for breakfast—ham, sausage, bacon, breakfast steaks—is an appetizing means of increasing the protein content of the morning meal. Its biologically complete protein contains all essential amino acids, and serves well in complementing less complete proteins from other sources. Furthermore, muscle meat is an outstanding source of B complex vitamins and of iron.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., *Ann. Int. Med.* 18:913 (June) 1943.

(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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[of menopausal symptoms] was striking within
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"Premarin."**

Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilinenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.



"PREMARIN"®



*Estrogenic Substances (water-soluble) also known as
Conjugated Estrogens (equine)*

Ayerst, McKenna & Harrison Limited
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A Doctor WHO RAISED HER OWN BABY ON BAKER'S SAYS...

As one who is supposed to know something about infant feeding formulas, and who has actually experienced making them, I have some special comments. With Baker's my baby has had almost no bowel trouble. I find it convenient to keep boiled water and then quickly mix fresh Baker's Milk formula as I need it, so that I never use formula which has been standing around for 24 hours or more. A more complicated formula has to be made at an opportune time and then put away for use. I prefer fresh formula — Baker's Formula.

My baby, Martha, has turned out to be a delightful child and healthier than most. Many new mothers, and fathers too, have asked how I fed her — so I advise Baker's.

Name on request.



Made in Wisconsin from grade A Milk

Baker's Modified Milk is a completely prepared formula for infants, requiring only one simple direction for use — "dilute to prescribed strength with water, previously boiled." In most cases, Baker's can be used from birth to the end of the bottle-feeding period. Write for complete information and samples.

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Comprise the entire properties of
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Each Pill is equivalent to one U.S.P. Digitalis Unit

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Nothing Competes with the Lure of Sweets



Use it in Sulfonamide Therapy

● Reactions ranging from mild antagonism to overt rebellion are to be expected when children are confronted with bad-tasting medicine. Contrast this with juvenile enthusiasm for DUOZINE *Dulcet* Tablets.

Here's medicine that sweets-loving small fry (and many adults) really enjoy—sulfadiazine-sulfamerazine disguised in orange-colored, candy-flavored cubes.

Mothers find DUOZINE *Dulcet* Tablets easy to administer in exactly the prescribed dosage. You'll find them effective in many systemic infections. The combined sulfonamides are independently soluble in the urine, with the result that high blood levels can be maintained with small likelihood of crystalluria and renal damage.

DUOZINE *Dulcet* Tablets, sulfadiazine-sulfamerazine in equal parts, are available in 0.3-Gm. and 0.15-Gm. potencies, bottles of 100. Mighty "take-able" medication when sulfonamides are indicated.

Abbott



See that the Rx reads



DUOZINE *Dulcet* Tablets

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® MEDICATED SUGAR TABLETS, ABBOTT

HABIT TIME OF BOWEL MOVEMENT



SAFE . . .

PETROGALAR[®], given at bed-time—not with meals—has no adverse effect on absorption of nutritive elements. It provides a relatively small but highly effective dose of mineral oil augmented by a bland, hydrophilic colloid base. The result is a soft-formed, easily passed stool, permitting comfortable bowel movement.

If preferred, PETROGALAR may be given thinned with water, milk, or fruit juices—with which it mixes readily.



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ON 30-DAY TEST OF CAMEL SMOKERS...

*"Not one single case
of throat irritation
due to smoking
Camels!"*

Yes, these were the findings of throat specialists
after a total of 2,470 weekly examinations
of the throats of hundreds of men and women
who smoked Camels—and only Camels
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MY DOCTOR'S REPORT
CONFIRMED WHAT I KNEW
FROM THE START—CAMELS
AGREE WITH MY THROAT.
AND I LIKE CAMEL'S
RICH, FULL FLAVOR!

HARRY SOUTHWELL,
lawyer, is one of hundreds,
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the 30-Day Test of Camel
Mildness under the observa-
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ACCORDING TO A NATIONWIDE SURVEY:

*More Doctors
Smoke Camels*

THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent
research organizations asked 113,597 doctors what cigarette they smoked. The
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R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

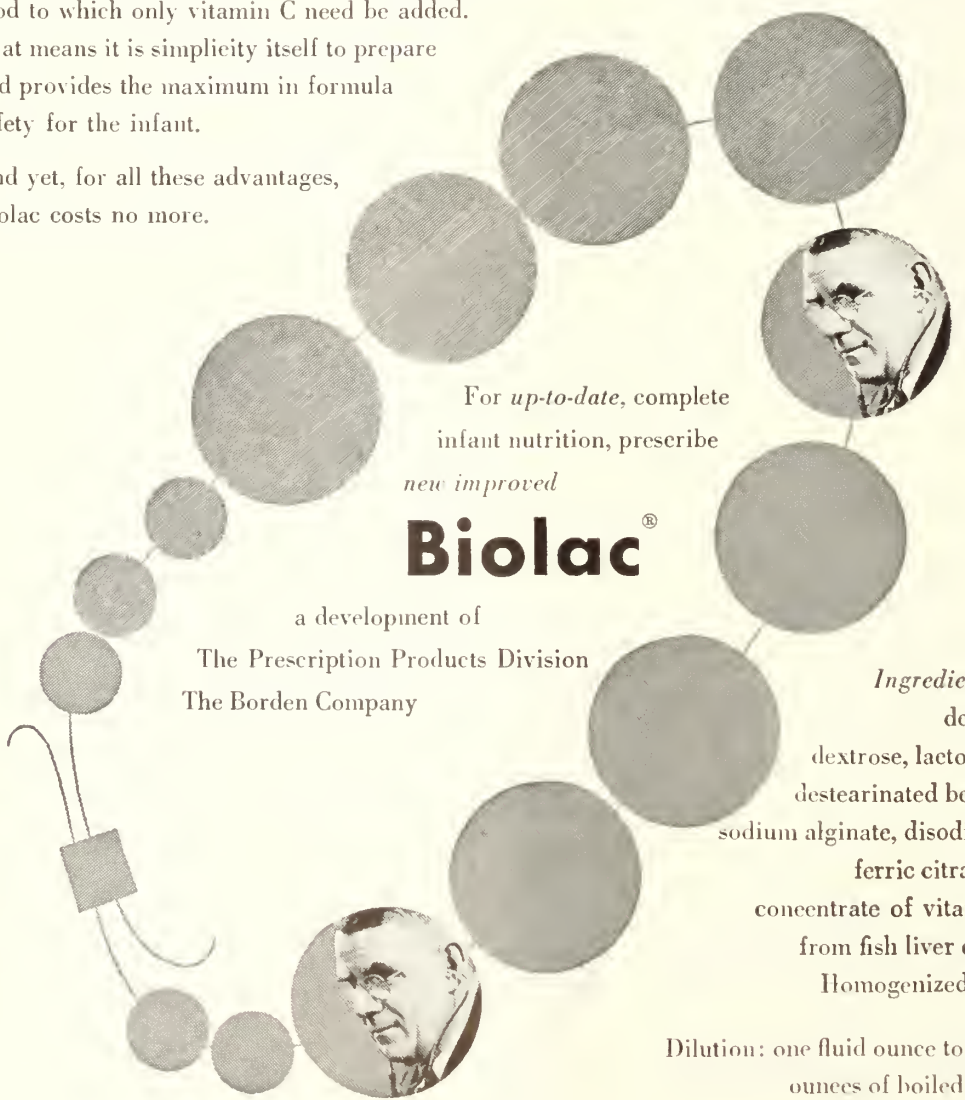


more physicians are satisfied

The development of the new improved Biolac supplies a long-sought need in infant nutrition. To accomplish this, Borden scientists surveyed our present nutritional knowledge. They then tested more than 500 formulations. Having decided on the formula that would best supply the normal infant's nutritional requirements in their most assimilable form, a modern plant was constructed in 1949 so that the new formula could also benefit from the most up-to-date techniques and control in processing equipment. A Biolac formula that is both new and improved is thus made available.

Biolac is intended for prescription by every physician with infants among his patients. It satisfies the physician's demand for a complete food to which only vitamin C need be added. That means it is simplicity itself to prepare and provides the maximum in formula safety for the infant.

And yet, for all these advantages, Biolac costs no more.



For up-to-date, complete
infant nutrition, prescribe
new improved

Biolac[®]

a development of
The Prescription Products Division
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Ingredients: skim milk,
dextrins-maltose-
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sodium alginate, disodium phosphate,
ferric citrate, vitamin B₁,
concentrate of vitamins A and D
from fish liver oils, and water.
Homogenized and sterilized.

Dilution: one fluid ounce to one and a half
ounces of boiled water for each
pound of body weight.

Biolac is available in 13 fluid ounce tins.



The Borden Company, Prescription Products Division

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Pure Crystalline Vitamin B₁₂

**The Only Form
Of This Important
Vitamin
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PREFERRED BECAUSE

potency, purity, and lack of toxicity of *crystalline* vitamin B₁₂ are clearly established.

Potency: Potency of this U.S.P. product is accurately determined by precise weight.

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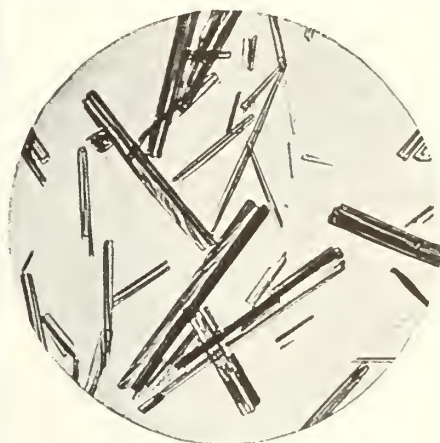
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In recent pharmacologic investigations, extremely large doses of *crystalline* vitamin B₁₂ (1,600 mg./Kg.) caused no toxic reactions in any of the animals treated. In contrast, 3 mg./Kg. of a "concentrate" caused fatal reactions in 100 per cent of the animals treated.

Merck—first to isolate and produce vitamin B₁₂—supplies Crystalline Vitamin B₁₂ in saline solution under the trade-mark Cobione.* Your pharmacist stocks Cobione in 1 cc. ampuls containing 15 micrograms of crystalline vitamin B₁₂.

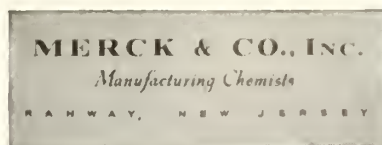


Crystalline Vitamin B₁₂

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Cobione is the registered
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COURAGE IN MEDICINE

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Pittsburgh, Pa.



ONE CANNOT accept the presidency of an organization, which has devoted itself for 102 years in a voluntary way to the health and welfare of the people of this Commonwealth, without a deep sense of gratitude to

the members of this Society—gratitude, not for the honor of position, but for the opportunity to continue to be of service in such a constituent society and to all of organized medicine. And, too, one rightfully feels very humble when he considers that he is merely the 101st doctor that has served in this capacity. It is with this sense of humility and appreciation of the confidence evidenced by the membership of the State Society that I proudly and gladly accept the duties of its presidency.

Very recently, while driving from Pittsburgh to Harrisburg early on a beautiful morning, enjoying the beauty of the green hills and valleys and admiring the marvel of engineering skill over which I motored, I thought of the vision of Andrew Carnegie when he directed the boring of those first tunnels through several mountain ranges many years ago and of the skill of the men of engineering science and construction,

who in recent years laid those twin ribbons of concrete across western Pennsylvania. I know the obstacles to their progress were many, and at times they must have been confronted with difficulties that seemed insurmountable. But their *courage* completed the task.

And then I thought—has it not always been the same with the men of medicine—has it not been the devotion of the individual doctor, of the medical scientist, and the high purpose of organized medicine that have been responsible for the profession's accomplishments? The archives of medicine are replete with tales of the privations of our scientific investigators, of sacrifice of personal income, and of the difficulties imposed on them by the ignorant, the suspicious, and the fanatics—but their *courage*, their determination, their zeal for scientific advancement have carried them through and resulted in many of the great and beneficial discoveries and developments in medicine.

Just as the individual physician has had to demonstrate his mettle in keeping pace with scientific advancement, so has organized medicine been continually confronted with many and various difficulties and has constantly, through the years of its existence, shown its determination to strive for the best in medical service and for progress in public health and welfare. And when we speak of organized medicine, we mean the

Presidential address delivered at the Installation Meeting of the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia, Oct. 17, 1950.

American Medical Association and its component county and state medical societies.

It would seem that doctors should be let alone and permitted to devote their time and energies to improving their own knowledge of medicine and to applying this knowledge to the purpose of providing better medical care for the people of the country. But the social, economic, political, and cataclysmic problems which have been thrust upon the AMA in the 103 years of its existence have been astounding. For more than a decade we have had to fight not only to maintain high educational standards but, at the same time, to preserve the right to continue to practice medicine free from political control. The energy and substance of the AMA have been devoted to the defeat of governmental attempts to impose on the people of this country political and bureaucratic medicine. And now we are confronted again with the necessity of sharing our medical manpower with the armed forces of our country, both at home and overseas. War may not have been officially declared, but when our troops, including physicians, dentists, nurses, and other personnel, are being shot and killed overseas—there is a war going on! Our profession has suffered with all the citizens of our country the impact of four major wars during the memory of many in this room, for many of us recall the war slogan "Remember the Maine" and the charge of San Juan Hill.

While our attention is largely focused on these major problems and difficulties, there are many other movements, stealthy and insidious, which, if successful, will have a terrifying effect upon medical progress. The antivivisectionists, who now wish to be known as the National Humane Education Association, would deny us the right to use animals in medical research in this and other states. Today there would be no penicillin, no insulin, and no miraculous surgical relief for "blue babies" had it not been for animal experimentation in medical research. And it now becomes necessary to again throw our resources into a contest in the legislatures of many states to preserve our right to continue in medical research.

The courage of our doctors as individuals in recognizing and conquering such a danger to the public, and of the AMA as our directing body, is resulting in very satisfactory progress.

The group of physicians who have completed the three-year program of the Graduate Educa-

tion Institute and who are being honored tonight exemplify the desire of the doctor to constantly improve his own knowledge of medicine so that he may justify our claim that we do render to the American people the best medical care in the world. We sincerely appreciate the many days they have spent in postgraduate study and the sacrifices they have made in this achievement as their contribution to better medical service.

The vision in perspective displayed by the AMA in its direction of our National Education Program in opposition to political medicine is producing results highly favorable to the profession and those we serve. Senators who would deny us our rights have already felt the sting of defeat. The proponents of political medicine in the higher levels of our government, who describe our educational campaign as "fighting the government," have found it necessary to devote much of the time of their staff assistants to the development of propaganda against us, and to spend large sums of the taxpayers' money illegally in prosecuting their campaign of publicity. Nevertheless, members of the Federal Congress have listened to us and have refused to adopt executive reorganization plans which would place health under bureaucratic and political control with labor and welfare.

With *courage* we shall carry on. We shall continue to improve our own knowledge of medicine and to provide ever improving medical service. We shall continue to resist the attempts of politically inspired bureaucrats to obtain control of the practice of medicine in this country. As individuals, but not as a political organization, we must learn the attitude of those who seek public office and then inform our patients and friends as to which candidates are most interested in the general welfare of all and those who are motivated only by political expediency and return to public office. We will protect the advancement of medical science from the depredations of unskilled cults and the machinations of ignorant fanatics. We will cooperate with the authorities in the procurement and assignment of doctors of medicine for the care of our armed forces at home and abroad. With a depleted membership we will continue to care for those at home. And we will seek the knowledge we must have and create the organization necessary to cope with atomic disaster and the catastrophic emergencies of global war, if and when carried to our own fair land.

The role of medicine is an intimate part of the life of every individual in this country. It is an honorable profession, activated by the desire of its members to render the greatest possible service to the people of this country. Loyalty to the high calling of our profession and *courage* in adversity are the priceless ingredients in molding our aspirations. But, as long as we hold above all else advancement of the health of our people, our future is secure. I have faith in the physicians of this country, and I sincerely hope the people of our country will have the same faith in the *courage*, the aims, the steadfastness of purpose, and all of the long-established public service policies of our parent organization—the American Medical Association.

If we are to realize the hope I have expressed, each of us must recognize his own fundamental obligation, namely, that it is not enough to tell people what we believe; rather we must *demonstrate* what we believe through our actions, our attitudes, and our display of unselfish inter-

est in their welfare. *Each* of us then must accept an inherent challenge that the reputation of the medical profession in the eyes of the public depends very largely upon each physician's own personal conduct. We judge others by generalities, and not by painstaking observation. It necessarily follows that the average person judges the medical profession by the doctors he has known. This is oft-repeated advice. In bringing it to you, however, I accept it for myself and lay it before you, my hearers, members of a profession whose service should mean comfort and prolonged life to an increasing number of people each succeeding year.

Tonight—as you and I dedicate ourselves to another year of wholehearted effort to the care of the sick, to the advancement of the span of human life, and to the preservation of our right to practice free medicine in a free country—may we justify as our earned reward the faith and confidence of all the people of our country.

HORMONE THERAPY

The publicity accorded to recent dramatic advances in clinical endocrinology has intensified interest in hormone therapy among physicians and laity alike. This has resulted in increased pressure upon the physician, from his patients as well as through advertising propaganda, to prescribe endocrine products for a wide variety of disorders.

Therapeutic hormone preparations are of two general types. The first group, those which stimulate certain target tissues (trophic effect), includes gonadotropins derived from chorionic tissues, pregnancy serum, and the anterior pituitary; and the lactogenic (prolactin, luteotropin), adrenocorticotrophic (ACTH), and growth-promoting factors of the anterior pituitary. The second and larger group, those which act as substitutes for functionally deficient endocrine organs, includes epinephrine; a variety of the components of the adrenal cortex (aqueous adrenal cortex extract, lipo-adrenal extract, desoxycorticosterone, cortisone); desiccated thyroid and thyroxin; the parathyroid hormone; insulin; and various synthetic and naturally derived preparations which exert the effect of androgen (testosterone), estrogen (stilbestrol, estradiol, estrone and estriol compounds), and progestin (progesterone, corpus luteum hormone).

The clinical response to the gonadotropins and to the lactogenic hormone is more or less unpredictable, and presently available preparations of the pituitary growth factor are probably inert. Under suitable conditions,

however, the other substances mentioned consistently produce clear-cut physiologic effects, which usually persist as long as treatment is continued. Excessive dosage may be detrimental or even fatal, e.g., the production of some of the phenomena of Cushing's syndrome following the use of ACTH; angina pectoris, auricular fibrillation, and heart failure following desiccated thyroid; hydremia and congestive heart failure following desoxycorticosterone; mastodynia and irregular uterine bleeding following estrogens. It may be unwise to employ hormones for their general metabolic effect unless there are clear-cut indications for their use. Desiccated thyroid, for example, is often used improperly in the treatment of obesity. Estrogens and androgens are frequently administered without a critical analysis of the therapeutic problem. Most hormone preparations are still rather expensive and many require parenteral administration. In view of the expense and inconvenience to the patient and particularly in view of the potential dangers involved in excessive or ill-advised hormone therapy, it becomes the physician's responsibility to exercise particular care and judgment in planning treatment. Three basic principles should be kept in mind: (1) careful analysis of the diagnostic or therapeutic problem should precede the institution of treatment; (2) with few exceptions, the optimal dose is the minimal effective dose; (3) every patient receiving hormone therapy should be examined periodically for evidence of overdosage or undesirable side effect—EDWARD ROSE, M.D., *Philadelphia Medicine*, June 3, 1950.

Clinical and Surgical Considerations of Intrathoracic Tumors

STUART W. HARRINGTON, M.D.

Rochester, Minn.



IT IS indeed a great pleasure for me to participate in the hundredth annual meeting of this society of my home state, and I am pleased that you have asked me to discuss with you some of the clinical and surgical considerations of intrathoracic tumors, as this is a subject in which I have been interested for the past 25 years. During this period, knowledge of the different histologic types of tumor that occur within the thorax, methods of establishing a diagnosis, and methods of treatment have increased rapidly. However, even though all of the present methods of diagnosis are utilized, these tumors still present many problems concerned with the establishment of a definite clinical diagnosis and in the determination of the type of treatment to be instituted.

The incidence of these growths is probably no greater now than it has ever been. However, interest in the diagnosis and treatment of these tumors has increased in recent years because their presence is being recognized more frequently. One of the principal reasons for this more frequent recognition is the present use of routine roentgenographic examinations of the thorax, regardless of whether or not the patients present symptoms referable to the thorax.

Before the advent of roentgenologic methods of diagnosis, the presence of these tumors was determined from the subjective symptoms and from the findings on physical examination of the thorax. In most instances it was impossible to determine the type of lesion, whether the tumor originated from the tissue of the lung or from the structures in the mediastinal spaces outside the lung. During this period the diagnosis usually was obtained so late in the course of the disease that conservative methods of treatment had

to be employed, because surgical treatment was considered a hazardous procedure, was seldom used, and was rarely successful. Studies made at that time to determine the character of these tumors were based on inspection of long-standing lesions, and at necropsy it was thought that most of these tumors were malignant.

The use of roentgen rays in diagnosis has made it possible to recognize these lesions early, before they have made serious inroads on the patient's general condition. The lack of response of most of these tumors to conservative treatment has encouraged surgical intervention with the objective of complete removal. The marked advancement in surgical technique has made operative removal of these lesions relatively safe. Study of these early lesions has given a different conception of the type of tumor found in the thorax and of the prognosis from that formerly held. Microscopic study of these early lesions, for instance, has shown that a large percentage of them are benign. Nonetheless, all intrathoracic tumors should be considered to be potentially malignant. Tumors that remain benign often attain enormous size; they may even cause death from mechanical pressure on the important structures in the thoracic cavity which are adjacent to the tumor. These structures either control or are closely associated with respiration, circulation of arterial and venous blood and lymph, deglutition, as well as the functional innervation of organs lying outside the thorax.

Because of the potentially malignant character of these tumors and their close proximity to the important structures contained within the thorax, it is of paramount importance that such lesions be recognized early, and that treatment be instituted immediately before a tumor has caused serious and permanent injury from pressure to the vital thoracic structures or has undergone malignant change. In primary malignant tumors,

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From the Division of Surgery, Mayo Clinic, Rochester, Minn.

early diagnosis and operation are essential because of the greater possibility of complete removal and less likelihood of distant metastasis if they can be treated soon enough.

The clinical manifestations of intrathoracic tumors are often meager and rarely pathognomonic, although when present, they are of value when correlated with the roentgenologic findings in the establishment of a final diagnosis and in the selection of the type of treatment to be instituted. Even after correlation of the results obtained by application of all the modern thoracic diagnostic methods, it is often impossible to determine clinically the type of lesion that is present or whether the tumor is benign or malignant.

Roentgenologic Factors

For many years the medical profession has carried out roentgenographic examinations on patients who seek medical attention for some definite complaint, but only in recent years has it been done as a routine diagnostic procedure on large groups of people who have no definite complaint. When an abnormal condition which is indicative of the presence of a tumor is shown in a routine roentgenogram, it is important that complete roentgenologic and physical examinations be made to determine the type of lesion. This should be done regardless of whether or not the condition has caused any symptoms because early diagnosis and immediate institution of treatment are of the utmost importance in the treatment of these tumors.

It must be kept in mind that many different types of tumors in various locations in the thorax and mediastinum have similar roentgenologic

manifestations, and a definite diagnosis often cannot be established even after utilization of all the different roentgenologic means, such as roentgenoscopy, angiocardiology, and examination of the esophagus and stomach after the patient has ingested barium, to rule out any possibility of a lesion of, or impingement on, these structures. In many instances, after utilization of all other methods of thoracic diagnosis, such as bronchoscopy, thoracoscopy, esophagoscopy, examination of sputum for malignant cells or organisms and so on, a definite diagnosis cannot be established.

Anatomic Situations

From a study of the types of tumors in cases in which the diagnosis has been proved by histologic examination, it has been found that the position of the tumor in the thoracic cavity is of great value in suggesting the type of tumor present, for certain types of lesions are more likely to occur in certain locations than in other locations.

Anterior Portion of the Thorax.—In a general way it may be stated that the types of tumors most frequently encountered in the anterior part of the thorax are the various teratoid neoplasms, mesodermal (Fig. 1), entodermal, and ectodermal (dermoid cysts), but such tumors occasionally are found in the posterior mediastinum also. Other lesions which may be found in the anterior part of the thorax are thymic tumors, cystic tumors, peripheral pulmonary tumors, lipomas, fibromas, intrathoracic thyroids, and various types of connective tissue tumors.

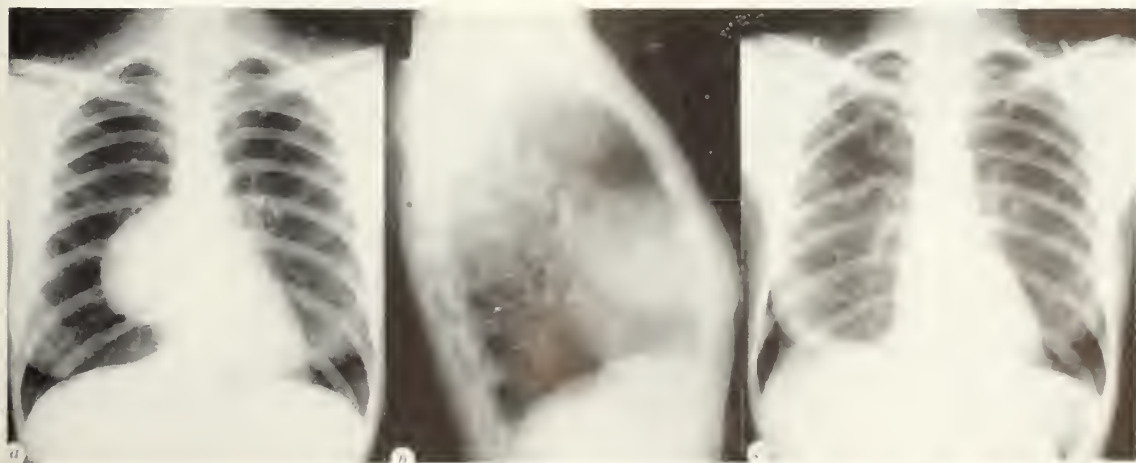


Fig. 1. The patient, a woman aged 33 years, had an anterior mediastinal teratoma. *a.* and *b.* Unremoved tumor as right border of heart and anterior mediastinum superimposed on heart shadow. *c.* Four years after complete right transpleural removal of tumor.

Posterior Portion of the Thorax.—The tumors most commonly located in the posterior portion of the thorax are perineural fibrosarcomas or neurofibromas, although these tumors (Fig. 2) also may be located along the course of the nerves along the lateral wall of the thorax, as well as in the spinal column. Other lesions found in this region are granulomatous lesions of the mediastinal lymph nodes or parenchyma of the lung, tumors of the esophagus, peripheral pulmonary tumors and cysts (Fig. 3).

Middle of the Thorax.—The lesions most commonly seen in the middle of the thorax are those of the great vessels, intrapulmonary lesions, cardiac lesions, aneurysms, and lymphoblastomas. Distinction of lesions in this location requires the greatest care from a surgical standpoint, because many lesions in this region are not amenable to surgical treatment although some can be treated surgically.

Superior Portion of the Thorax.—Distinction of tumors of the superior part of the thorax often is difficult because they frequently fill the entire space, so that it is difficult to determine the relationship to the surrounding viscera (Fig. 4). The tumors most commonly located in this region are thymomas, intrathoracic goiters, neuroblastomas, aneurysms, cystic lymphangiomas, as well as cysts of the lung and cystic azygos lobes.

Lower Portion of the Thorax.—The lesions most commonly found in the lower part of the thorax above the diaphragm are cystic or solid tumors associated with the pericardium, tumors or diverticula of the lower part of the esophagus

(Fig. 5), and lesions of the diaphragm which may simulate intrathoracic tumors; these consist of subcostosternal hernias (foramen of Morgagni) containing omentum only or hernias of the liver through the dome on the right side of the diaphragm.

Symptoms

One of the most important considerations of these intrathoracic growths is that they may cause no subjective symptoms. The absence of symptoms is rather common in benign lesions, but also early malignant lesions may produce no symptoms, particularly if they are extrapulmonary, and occasionally if they are peripheral and intrapulmonary. However, most of these lesions do present some clinical manifestations and the subjective symptoms, when present, vary depending on the type of intrathoracic tumor present as well as on the duration and location of the tumor in the thorax.

Tumors situated in the anterior mediastinum as a rule cause more symptoms than those situated in the posterior mediastinum, because of the small space in which they are confined and their proximity to the lung. This is true whether the lesion is benign or malignant. Pain is one of the most important subjective symptoms of these growths. Anterior mediastinal tumors usually are accompanied by pain, whether they are benign or malignant, but the pain of benign tumors is of a different character and is never as severe as that associated with malignant lesions.

When the lesions are benign, the patients have a sense of pressure beneath the sternum, usually

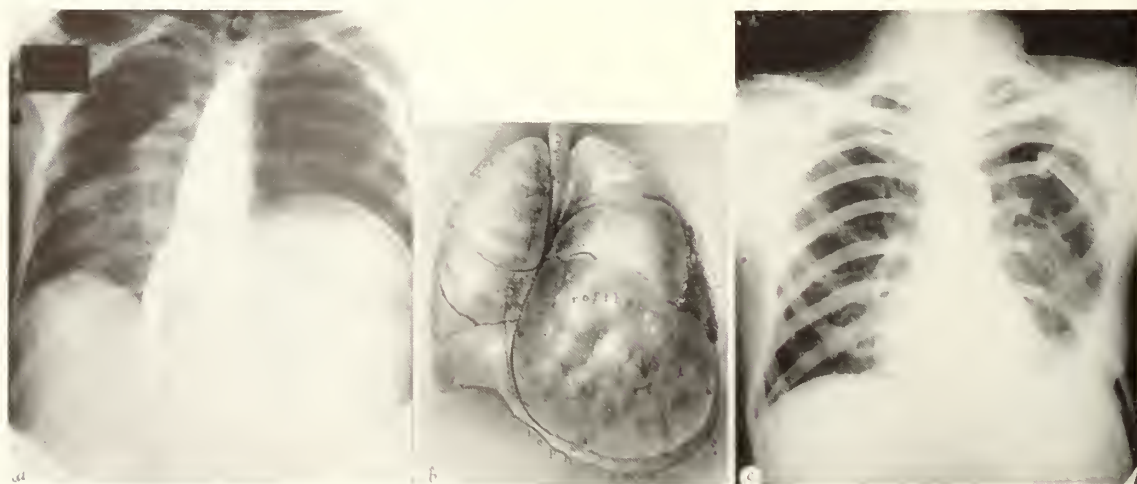


Fig. 2. The patient, a man aged 25 years, had a large neurofibroma of the left lower part of the thorax. Tumor had been present for six years and could be palpated in left upper quadrant of abdomen. *a.* Tumor occupying entire left lower part of thorax displacing diaphragm downward and heart and esophagus into right side of thorax. *b.* At operation: large tumor displacing esophagus and diaphragm. Collapse of lower lobe of left lung. *c.* After transthoracic complete removal of tumor; left lung expanded.

associated with dyspnea and cough on physical effort. These symptoms are progressive in character and are associated with, and augmented by, inflammatory lesions of the respiratory tract. These tumors are commonly diagnosed as pulmonary or pleural lesions, such as pleurisy, pneumonia, or influenza. When anterior mediastinal tumors become malignant, the pain is usually more severe; at first it occurs periodically and is noted mostly at night. It gradually becomes more or less constant until sedatives are required for relief.

Posterior mediastinal tumors may be benign or malignant. Benign tumors in this location are the most silent tumors that occur within the thorax. The outstanding clinical features are relatively few, and only mild symptoms may be associated with large growths, for these tumors may fill practically the entire hemithorax without producing any marked symptoms other than dyspnea on exertion. In some instances neurologic symptoms, consisting of varying degrees of paralysis, are associated with tumors in this region, particularly when tumors are neurogenic, such as dumbbell tumors which extend into, and cause pressure on, the spinal cord, or gangliomas which are common in the superior mediastinum and may cause Horner's syndrome or anhidrosis. When tumors situated in this region are malignant, or have undergone malignant change, relatively small growths are associated with severe pain; the patient's chief complaint then is of the pain.

Dyspnea and other clinical manifestations are usually more marked when the tumor is situated in the superior mediastinum, because in this region the growth not only produces pressure on the lung itself but in many instances it causes direct pressure on the large bronchi and on the hilus of the lung; at times, also, it exerts pressure on the trachea and thus causes marked interference with respiration, particularly on exertion. These tumors may also compress the esophagus and cause difficulty in swallowing.

Surgical Indications

Intrathoracic lesions for which surgical treatment is advisable may be divided into two groups, from a clinical standpoint: (1) those that are causing subjective symptoms and (2) those that are not causing subjective symptoms and are found on routine clinical examination. For the first group, surgical treatment is a gen-

erally accepted tenet and, when indicated, should be carried out without delay. Concerning the second group, there may be some difference of opinion as to whether surgical treatment is indicated immediately or whether the patient should be kept under observation. This latter group presents one of the more important problems associated with intrathoracic lesions at the present time because of the relatively frequent finding of symptomless lesions on routine roentgenographic examinations. Each lesion must be dealt with individually; the manner depends on the findings.

Every effort should be made to establish a definite clinical diagnosis, but in many instances this cannot be accomplished. When the roentgenographic findings are those of a lesion which cannot be differentiated from one which requires surgical treatment, especially a malignant lesion, I believe that an exploratory thoracotomy should be performed and tissue should be removed for the establishment of a definite histologic diagnosis. I hold to this unless operative treatment is contraindicated for other reasons, such as the patient's general condition. My reason is that the risk of exploratory thoracotomy is very small owing to the marked improvement in technical surgical methods and preoperative and postoperative measures. In those cases in which exploratory operation is required to establish a diagnosis, the lesion should be completely removed at that time if the operation reveals that it can be.

The methods of approach to, and the types of operative procedures for, intrathoracic growths depend on the site of the tumor, its extension within the thoracic cage, and the presence of complications which may have been produced by the growth. In each case the surgical procedure must be selected individually, on the basis of the indications presented. A few general principles apply in all cases. Some of the more important are the selection of the location and method of approach through the chest wall which will give the greatest exposure of the tumor with the minimal amount of trauma and removal of normal structures of the thoracic wall. These are necessary so that at the completion of the operation the thoracic wall can be completely reconstructed in order to restore the normal relations of the thoracic viscera and give the minimal amount of deformity of the chest wall.

The more important factors related to removal of the tumor are early operation and complete

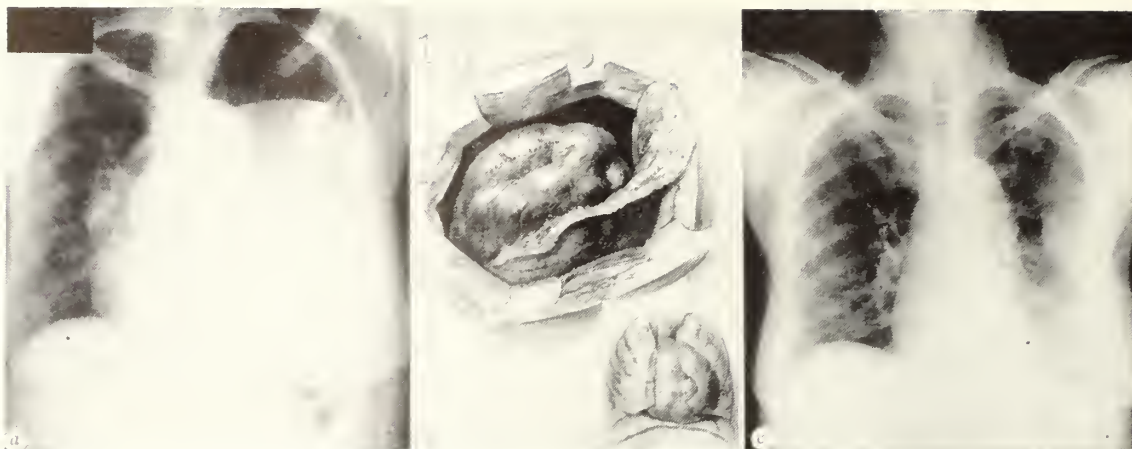


Fig. 3. The patient, a woman aged 70 years, had a neurofibroma with areas of neurofibrosarcoma, grade 2, attached to the pericardium. *a*. On admission, large anterior mediastinal tumor filling left lower part of thorax and mediastinum and displacing heart. *b*. At operation. Large tumor extending into both halves of the thoracic cavity, compressing lower lobe of the left lung and displacing the heart. *c*. On dismissal four weeks after posterior transthoracic complete removal of tumor. Left lung expanded. Heart in normal position.



Fig. 4. The patient, a girl aged 7 years, had a ganglioneuroma of the left superoposterior part of the thorax with Horner's syndrome. *a* and *b*. On admission showing circumscribed tumor of left superior part of the posterior mediastinum with widening of second intercostal space and pressure erosion of second and third ribs. *c*. Left Horner's syndrome.



Fig. 5. The patient, a man aged 53 years, had a leiomyoma involving two thirds of circumference of lower part of esophagus. *a*. Rounded mass in right cardiophrenic angle, posterior to heart shadow. Diagnosis was diaphragmatic hernia or mediastinal cyst, both questionable. *b*. Tumor (leiomyoma) attached to and distorting lower part of esophagus to right; a hiatal hernia also may be noted. *c*. Six weeks after complete right transpleural removal of tumor with reconstruction of wall of esophagus. Lumen of esophagus is free. Small hiatal hernia.

removal of the tumor at the time of operation and repair of any damage to surrounding structures which may have been caused by the presence of the tumor or the removal of the tumor from these structures.

The approach to intrathoracic tumors varies according to the location of the growth. Anteriorly located tumors may be approached through the anterior or posterior wall of the thorax. I prefer the posterior approach, particularly when the tumor projects into either pleural cavity. The posterior approach gives much greater exposure than the anterior approach, and it permits dissection under direct vision of the tumor from the important structures to which it may be adherent. These usually are the heart, the great vessels, and the lungs. Furthermore, any injury to these structures caused by the tumor or operative procedure can be detected and repaired immediately, and if infection is encountered, drainage can be instituted readily.

If the tumor is small and is confined to the anterior or superior mediastinum, or if it has ruptured into the lung anteriorly, the growth may be more accessible if approached anteriorly. This may be achieved by splitting the sternum or removing the cartilage and turning back the wall of the thorax. In many instances such tumors can be removed extrapleurally through an anterior type of incision, while the operation is transpleural when the posterior approach is used.

The approach to posterior mediastinal tumors is practically always through the posterior thoracic wall, and an attempt should always be made to remove the tumor extrapleurally. This, however, rarely can be accomplished and only in cases in which growths are small, for the tumor usually is adherent to the parietal pleura, which is ultimately opened; in some instances the tumor is placed so far back in the mediastinum that it is impossible to dissect the pleura away from the thoracic wall sufficiently to permit the removal of the tumor.

Tumors situated in both the posterior mediastinum and spinal cord, often called "dumbbell" or "hourglass" tumors, are removed by posterior mediastinotomy and laminectomy. This operation may be done in one or two stages. If the tumor is removed in two stages, the intraspinal portion of the tumor should be removed first after laminectomy to minimize the danger of permanent damage to the spinal cord from pres-

sure caused by edema of the tumor or hemorrhage into the spinal canal. The mediastinal portion of the tumor usually can be removed by posterior mediastinotomy 10 to 14 days later. The two-stage procedure is usually indicated when the mediastinal portion of the tumor is large because collapse of a large amount of lung and other intrapleural complications may greatly increase the operative risk.

When the mediastinal portion of the tumor is small, the two procedures may be done at one time through two separate incisions. The laminectomy is done first to expose the intraspinal portion of the tumor and then posterior mediastinotomy is done with complete removal of both portions of the tumor through the mediastinum. This one-stage procedure is preferable in selected cases because any possibility of leaving a portion of the tumor is avoided, hemostasis can be more accurate, and in some cases the mediastinal portion of the tumor can be removed extrapleurally.

For tumors situated in the posterior portion of the thorax, a posterolateral incision is made around the vertebral border of the scapula. The entrance into the thoracic cavity is made by partial resection of one rib over the most central portion of the tumor and, when greater exposure is required, resection of 2 cm. of the ribs above and below is usually adequate to permit removal of even very large tumors.

The most inaccessible intrathoracic tumors are those located in the upper portion of the thoracic cavity between the first and sixth ribs posteriorly, because these ribs are covered by the scapula. When these tumors are located posteriorly and in some of the anteriorly located tumors, they can be satisfactorily removed by removal of the fourth rib posteriorly after elevation of the scapula.

After the tumor has been completely removed, any injury to surrounding structures should be carefully repaired and all bleeding points should be carefully ligated. Any raw surface produced by the removal of the tumor should be covered as much as possible with pleura. The pleural cavity is then irrigated with physiologic salt solution to remove any particles of tissue or blood clots, the lung is fully inflated by increasing the positive pressure, and 240,000 units of penicillin is placed in the pleural cavity. The incision is then closed. The pleural cavity is drained by airtight or closed type of drainage with a 22 F.

catheter and application of gentle suction to the catheter. Institution of closed drainage is usually through the posterior portion of the periosteum of the rib which has been resected or, if this is not an adequate position for drainage of the pleural cavity, a closed type of intercostal drainage is instituted posteriorly through the eighth interspace. In this way the bloody serum which usually collects after removal of intrathoracic tumors or after trauma to the pleura is drained. The immediate drainage of this bloody serum permits rapid and complete re-expansion of the lung and rarely continues for more than 48 or 72 hours, at which time the drainage tube may be removed.

Postoperative Care

The postoperative care of these patients is important and may be divided into two periods: (1) the immediate postoperative care in the operating room and (2) the subsequent postoperative care after the patient returns to his room. The immediate postoperative care begins at the time of operation and consists of the supportive measures needed to maintain the blood pressure and relieve any respiratory difficulty during the operation. It is usually advisable to use some type of medication during the operation or afterward. If much blood is lost during the operation, a transfusion should be given.

Respiratory difficulty is the most serious immediate complication after operation and should be entirely relieved before the patient is taken from the operating room. The trachea and bronchi should be aspirated through the intratracheal tube before it is removed. If there is excessive mucus, bronchoscopic aspiration should be performed before the patient is removed from the operating room. Roentgenograms of the thorax and upper part of the abdomen should be made while the patient is still on the operating table; films should be developed immediately and read before the patient is removed from the operating room. If roentgenograms of the thorax show pulmonary congestion or collapse of the lung, immediate measures should be taken to correct the condition, and further roentgenograms should be taken and again read before the patient is returned to his hospital room.

It is most essential not to remove the patient from the operating room until the bronchi are entirely clear of mucus, and on some occasions it may be advisable to keep the patient in the operating room until he has fully recovered from

the anesthesia and the cough reflex is established. This is rarely necessary, but in some cases in which the lung has been more or less collapsed by the tumor for a long time, it does not re-expand readily after removal of the growth. In many cases the pulmonary congestion can be minimized greatly if the lung is not permitted to be collapsed more than 10 to 15 minutes at one time during removal of the tumor. After being collapsed for this period of time, the lung should be fully re-expanded for three or four minutes to re-establish aeration and circulation of the blood before it is permitted to collapse again and removal of the tumor is continued.

If the roentgenograms of the upper part of the abdomen show dilatation of the stomach with gas, which not infrequently occurs following use of positive pressure anesthesia, this should be relieved immediately by the use of an indwelling stomach tube which is placed on suction. This tube may be removed after the accumulated gas has been removed or it may be left for a few days during the patient's immediate convalescence to remove any gastric secretions and to prevent vomiting. If this gas is permitted to remain in the stomach, it may cause acute dilatation.

When the patient is taken from the operating room, he is placed in an oxygen tent in which the concentration of oxygen is maintained at 50 to 55 per cent. The tube in the pleural space is placed under gentle suction or under water for closed drainage. The patient is kept in oxygen for varying periods; the duration depends on whether or not respiratory difficulty occurs. However, after removal of the extrapulmonary lesions, oxygen is rarely necessary for more than 24 hours. The subsequent postoperative care consists of measures to re-establish normal respiration and circulation and depends on the progress.

Series Studied

A series of 198 cases represents my experience in the surgical treatment of intrathoracic tumors. The classification of the 198 tumors of this series, based on a histopathologic study of the lesions, is as follows: 56 were neuroblastomas; 47 of these were located in the posterior mediastinum; six of these 47 were both posterior mediastinal and intraspinal tumors, so-called dumbbell or hourglass type of neurofibromas. Five of the 56 neuroblastomas were in the posterosuperior me-

diastinum, three were in the anterior mediastinum, and one was situated in the lateral wall of the chest. Three of the 56 neuroblastomas were malignant.

Thirteen of the tumors in the entire series were various types of fibromas or fibrolipomas, of which eight were malignant and were designated as sarcomatous. Roentgenologic findings and location of these tumors in the posterior mediastinum suggested a clinical diagnosis of probable neurofibroma.

Forty-two of the entire series were teratoid tumors. Thirteen were of the dermoid type of teratoma in which the predominating tissue was ectoderm. In these cases the epidermis lined the tumor and the teratoma in one was of such high degree of organization that it was termed a "fetal parasite." This tumor was covered with epidermis. Forty of these teratoid tumors were situated in the anterior part of the thorax and two in the posterolateral portion. Six of the teratoid tumors had undergone malignant change.

Thirty-seven of the tumors were cysts of the mediastinum. Of these, eight were celomic or pericardial cysts; eight were endothelial cysts; three were cystic lymphangiomas; ten were bronchogenic cysts; four were enterocystomas of the esophagus; and four were cysts of the azygos lobe of the right lung. None of these cysts were malignant. Cystic tumors of the esophagus and leiomyomas of the esophagus which may simulate posterior mediastinal tumors are not included in this series.

The 10 thymomas in the total series were in the anterior and superior mediastinum.

All of the 7 intrathoracic adenomatous thyroids of the series were below the third rib anteriorly and one extended to the diaphragm.

There were 5 endotheliomas and 5 hemangio-

endotheliomas; 13 were various types of granulomas in the middle and posterior mediastinum and most of these were associated with lymph nodes around the hilum of the lung and some extended into the lung; seven were hamartomas, of which one was entirely extrapulmonary and was situated in the anterior mediastinum; one lipoma in the anterior mediastinum; and two organized calcareous hematomas in the anterior mediastinum.

In all of the 198 cases, the tumors were removed by transcostal intrapleural or extrapleural operation and in the 6 cases of posterior mediastinal and intraspinal neuroblastomas of the dumbbell type, laminectomy and mediastinotomy were performed.

There were 7 operative deaths in the total series. Three of the patients who died had neuroblastomas; one of these patients had a tumor of the dumbbell type for which laminectomy and mediastinotomy were required. Two of the 7 patients had teratoid tumors, of which one was benign, and one had undergone malignant change. One patient had a thymoma and one a hemangio-endothelioma.

One hundred and ninety-one patients recovered from operation.

The series of 198 cases does not include the cases in which operations were performed for intrathoracic lesions in which a definite diagnosis could not be established clinically and those in which the lesions were those of the esophagus, such as leiomyoma or reduplication of the esophagus, diaphragmatic hernia of the congenital type in which the omentum is the only structure involved in the hernia, or hernias through the dome of the right side of the diaphragm which have placed a portion of the liver in the right thoracic cavity.

ANSWER CURRENT QUESTIONNAIRES PROMPTLY

Officers and committee members of your state medical society regret the necessity for sending questionnaires to every doctor of medicine in Pennsylvania, society and non-society members alike. Each may receive more than one questionnaire before the end of 1950. They are essential to the physical welfare of civilians and soldiers, all of whom may be suddenly exposed to injury or death during war-related emergencies.

Each physician may be needed; therefore, his whereabouts, his experience and availability must be known to those who plan in advance to meet disaster, wherever or in whatever form it may occur.

Please complete and return questionnaires promptly.

Human Leukemia, With Emphasis Upon Recent Therapeutic Experiences

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Definition

LEUKEMIA may be defined as an abnormality of the growth and maturation of the reticulo-endothelial system (found primarily in the bone marrow, lymph nodes, spleen, liver, and the connective tissues) characterized by the excessive formation of mutant or immature cells, which often resemble various stages of the normal maturative process of leukocytes, and may or may not circulate in varying numbers in the peripheral blood stream. The leukemic process may be compatible with life for as few as 20 days or for as many as 20 years. Complete (disappearance of leukemic cells from marrow and blood stream) or incomplete remissions of the process may occur for days or for years. The fact that leukemia has been observed to completely remit proves that it is curable. A similar status existed for pernicious anemia 30 years ago.

Leukemoid reactions which are sometimes indistinguishable from leukemia but which are caused by or follow various infections or poisonings are not in themselves fatal. However, *lymphemic reactions* usually do terminate fatally such as occurs when a malignant process, as lymphosarcoma, discharges its cells into the peripheral blood stream.

Classification

Leukemia may be classified according to its course, its duration, the quality and quantity of cells of which it is composed, its clinical manifestations, its pathology, etc. Clinically and practically, leukemia is classified as either *acute* or *chronic* depending upon the duration of the proc-

ess and the immaturity of the composing cells: or as *lymphoid*, *myeloid*, *monocytoid*, etc., depending upon the quality of the cells which may resemble lymphocytes, myelocytes, monocytes, etc. Acute leukemia seems to be an over-reproduction of the precursors of leukocytes and terminates fatally in less than 100 days, while chronic leukemia could be due to the progeny of a single mutant leukocyte¹ and may last from 100 days to 20 years. Occasionally there are patients with "mixed" leukemia, but as a rule the abnormal cells are variants of one cell strain, such as myeloid or lymphoid.

Leukemia has a duration of approximately 3.5 years when all types of cases are averaged.

Terminally, instead of hyperplasia of abnormal cells in the marrow, there may be fibrosis and even aplasia—the so-called "burnt-out" phases of leukemia.

Incidence

The incidence of leukemia is increasing rapidly; the rate has doubled in the United States in the last 20 years. Since the ability to diagnose leukemia has improved, due to better marrow studies which were made possible because of needle aspiration, the increased incidence is probably no greater than that of malignant disease of other organs and tissues. There are 15,000 to 20,000 cases of leukemia in the United States constantly, and about 5000 new cases each year (and, of course, about 5000 deaths annually). Leukemia occurs in the newborn, in children, in adults, and in the aged throughout the world. The majority of the cases of acute leukemia occur in the younger age groups, but many cases of chronic leukemia terminate in acute leukemia.

Leukemia occurs between eight and ten times more frequently in radiologists than in other

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physicians.^{2, 3} Two years following the atomic bomb blasts in Nagasaki, 4 cases of leukemia have been noted in the survivors—presumably an increased incidence.⁴

Etiology

The most promising theory for the cause of cellular hyperplasia of any type is that of intracellular deficiencies of specific enzymes or hormones. Infections, inheritance, mutations, hormones, chemicals, radiations, or a combination of the former may have etiologic significance, either primarily or secondarily.

Infections are not a likely cause of human leukemia because leukemic blood has been injected intravenously and intrasternally into humans without transmission.^{5, 6} The well-known case of the 50-year-old Sing Sing prisoner (Mr. Louis Boy) who survived after he had a complete exchange transfusion (18,000 cc. exchange) with an 8-year-old girl (Marcia Slater) who had acute lymphoid leukemia on June 1, 1949, proves that leukemia is not "easily transmitted." Marcia died June 14, 1949, fourteen days after the exchange transfusion, but Mr. Boy was hale and hearty in June, 1950. In 100 cases

of leukemia associated with pregnancy,⁷ not one offspring had leukemia at birth, nor did any have it as long as they were followed (the author has followed one case for 15 years). This evidence disproves placental transmission. Although viruses are the cause of chicken leukemia, no one has yet cultured viruses, bacteria, nor fungi from human leukemic cells whether obtained from blood or marrow. Of course, it is possible to theorize that an individual could inhale a virus particle which could reach a reticulo-endothelial cell and cause mutation of that cell. Progeny of the mutant cell would not necessarily have to be accompanied by an increased number of virus particles. The virus particle theoretically could be only the initiating factor and not necessarily the "continuing or sustaining factor."

In animals, leukemia may be an *inherited* process, but in humans there is little evidence at the present time that heredity plays a significant role in the etiology. There are occasional reports indicating that leukemia occurs in siblings,⁸ and lymphoid reactions may occur among relatives of patients with lymphoid leukemia.⁹ Out of 150 families studied, we had 4 cases in which siblings or parents and their offspring had leukemia. In

TABLE I

A list of patients with leukemia who had both clinical and hematologic remissions following various initiating processes, the most common of which was a spontaneous virus complication.

	Sex	Age	Occupation	Type of Leukemia	Complication or Treatment	Duration of Remission
1.	F	45	Housewife	Chronic lymphoid	Virus pneumonia	6 months
2.	M	50	Farmer	Chronic lymphoid	Splenectomy	12 months
3.	F	67	Housewife	Chronic myeloid	Transfusion from son who had influenza at the time of donation	6 months
4.	F	46	Physician's wife	Chronic myeloid	First—"cold" Second—transfusion (followed by a rather severe reaction)	12 months 6 months
5.	F	48	Nurse	Acute lymphoid (leukopenic)	Virus pneumonia	8 months
6.	M	42	Musician	Chronic myeloid	Spontaneous	11 months
7.	M	9	School boy	Acute lymphoid	Bronchopneumonia	4 months
8.	M	23	College student and later engineer	Chronic myeloid	Radiophosphorus	9 years
9.	M	3	.....	Acute lymphoid (leukopenic)	Bronchopneumonia with empyema	4 months
10.	M	48	Farmer	Chronic lymphoid	Hepatitis (serum)	8 months
11.	M	6	.....	Monocytoid	Chickenpox	6 months
12.	M	57	Retired farmer	Chronic lymphoid	Hepatitis (infectious)	6 months

one of our recent cases a son had chronic lymphoid leukemia at age 32 and died at 39, while his mother had subacute lymphoid leukemia at the age of 70, seven years after her son's death, and she has lived one year so far.

Some hematologists believe that leukemia is the result of a simple process of *mutation*—one or more genes of a reticulo-endothelial cell being damaged by radiations, chemicals (benzol,¹⁰ sulfa drug¹¹), or bacterial poisons, thereby causing the cell to mutate into a leukemic cell. Mutations should occur more frequently in cells undergoing rapid cellular division such as in the marrow which produces about one trillion red blood cells and 0.1 trillion white blood cells daily. No one knows the rate of mutation of normal human marrow cells, but Rhoads¹² states that bacteria mutate once in every 100,000 to 400,000 divisions. Mutations of reticulo-endothelial cells need not be irreversible processes because leukemoid reactions, which are occasionally associated with such diseases as pneumonia, tuber-

culosis, polycythemia, Pick's disease, whooping cough, infectious mononucleosis, carcinoma, lymphosarcoma, and periarteritis nodosa, or with chemical intoxications such as arsenic and sulfadiazine,¹¹ can and do disappear.

Some of the known *hormones* can affect the hematopoietic system. One pituitary hormone (ACTH) stimulates the adrenals, which in turn causes lysis of the lymphocytes. Another pituitary hormone—the thyrotropic hormone—can cause cortical degeneration of the adrenals associated with lymphocytic hyperplasia and with lymphocytic infiltration of many tissues, especially in the retrobulbar area. Cortisone—an adrenal hormone—when administered to patients with lymphoid leukemia, occasionally causes temporary remissions by presumably increasing myelopoiesis. When one realizes that insulin apparently augments the action of cortisone, that the growth hormone apparently inhibits the action of ACTH, that cytochrome C and sex hormones apparently inhibit both ACTH and cor-

TABLE II

A partial summary of some of the recent therapeutic agents used for chronic leukemia, including an analysis of the results, as stated in the text.*

Type of Treatment	Type and Number of Chronic Cases of Leukemia				Type of Remission	
	Myeloid	Lymphoid	Monocytoid	Eosino-philoid	Temporary (1 day to 1 week)	More Prolonged (1 week to 1 month or more)
<i>Sustaining:</i>						
Replacement transfusions	3	3	1	..	Fair	Poor
<i>Inhibitory:</i>						
Nitrogen mustard	10	18	6	2	Good	Fair
Triethylene melamine	6	8	...	1	Good	Fair
Urethane	18	14	3	..	Good	Fair
Radioactive phosphorus †	29	20	6	..	Excellent	Good
<i>Stimulative:</i>						
ACTH	2	7	1	1	Excellent	Poor
Cortisone	2	6	..	..	Excellent	Fair
<i>Competitive:</i>						
Anti-folic acids	9	38	6	..	Fair	Fair
Viruses						
Dengue	1	3	1	..	Fair	Poor
Rickettsial pox	1	1	..	..	Fair	Poor

* Acute leukemia responds poorly to any treatment. Aminopterin, cortisone, and ACTH may produce temporary remissions in acute lymphoid leukemia and lymphokentric acid urethane may in acute myeloid leukemia. Older therapeutic agents, such as x-radiation and Fowler's solution, are not included in this summary.

† 100 cases reported in 1941 (reference No. 27) are not included.

tisone, one can readily see that various enzymes and hormones can variedly affect the hemato-poietic system.

Radiations—cosmic, gamma, beta and x-rays—can cause intracellular ionization which can denaturate proteins and enzymes or alter genes which can result in abnormal intracellular chemistry and which could be responsible for the formation of leukemic cells. Humans receive between 2 and 20 r of cosmic * rays, depending upon geography and altitude, each 50 years. Cosmic rays can also produce, in the atmosphere, radioactive carbon which can be inhaled and deposited intracellularly. However, if leukemia is due to radiations of this nature, it seems strange that more humans do not die of leukemia. Of course, as mentioned before, there is a high incidence of leukemia in radiologists. And, therefore, radiations could be considered as one of many inciting agents.

There are many similarities between pernicious anemia and leukemia since both are usually cellular hyperplasias of the marrow and both were fatal until 1925. Now vitamin B₁₂—an enzyme—can cause complete remission of pernicious anemia. Leukemoid reactions resemble a deficiency process, since as soon as the primary disease process disappears, so do the leukemoid cells—just as megaloblasts and macrocytes disappear after pregnancy has been terminated in a case of “pernicious” anemia of pregnancy. At present, at least, the leukemic process resembles a *deficiency state* as closely as does pernicious anemia. And it is hoped that extracts of fungi or yeast will be found that will mature immature leukocytes as the extract (B₁₂) of fungi (*Streptomyces*) has matured immature erythrocytes of pernicious anemia.

Some investigators believe that leukemic processes worsen because the leukemic cells excrete hormones that cause normal reticulo-endothelial cells to become leukemic—an autocatalytic process, while others believe that leukemic cells proliferate more rapidly terminally because of a progressively greater deficiency of maturative substances.

Pathology

There are some common findings in patients with leukemia: the basal metabolic rate is usually increased, probably due to the large number of rapidly metabolizing cells and not overactivity

of the thyroid gland; the blood levels of uric acid, phosphorus, potassium, and iodine are increased, probably due to the rapid metabolism of cellular proteins; also, abnormal urinary products are excreted as a result of abnormal cell metabolism. These excretion products may or may not have etiologic significance.¹³

The leukemic cells frequently exist side by side with normal leukocytes in both the marrow and the circulating blood. Therefore, there may be two or more types or populations of circulating white cells in these patients. However, neither normal leukocytes nor leukemic cells usually have invasive capacities, but usually have only infiltrative abilities. (Leukosarcoma cells—lymphemic reaction of lymphosarcoma—may have invasive abilities.) Leukemic cells are often classified according to their stage of morphologic differentiation, and the more immaturity of the cells, the more acute the process as a rule. In terminal stages, some leukemic cells differentiate into scar tissue resulting in myelofibrosis; others into osteoid cells resulting in myelosclerosis. After all, leukemic cells as well as normal cells can divide, differentiate, mutate, or die.

Death of leukemic patients is usually due to:

1. *Anoxemia* of various organs due to infiltration of leukemic cells or due to the associated anemia (again due to leukemic infiltration of the marrow).
2. *Hemorrhages* from or into various organs such as the brain, stomach, kidneys, and lungs due to the associated thrombocytopenia (due to leukemic infiltration of the marrow and destruction of the megakaryocytes).
3. *Obstruction* of blood vessels or various ducts (bronchi, ureters, gall ducts) by enlarged lymph nodes, splenomegaly, hepatomegaly, etc., or by the infiltration of leukemic cells themselves.
4. *Biochemical deficiencies* since the leukemic cells rapidly utilize the available cellular nutrients.
5. *Infiltration* is the essential, fundamental pathologic feature of leukemic cells.

Treatment

Agents used in the treatment of leukemia may be divided into:

Sustaining agents—such as transfusions, antibiotics, antihemorrhagic substances, and nutrients.

* FIGGE, J. F.: Cosmic Radiation and Cancer, *Science*, 105 323, 1947.

Inhibitory agents—inhibitory to cellular metabolism, to mitosis, to adequate nutrition of cells, to normal cellular enzymatology, etc.

Stimulative agents—stimulants to normal cell metabolism such as hormones, enzymes, and catalysts.

Competitive agents—such as bacterial or viral infections, para-aminobenzoic acid, and antifolic acid derivatives.

Sustaining agents: Transfusions are indicated in leukemia when the red cell levels fall below 2,500,000/ cu. mm., the white cell levels below 2500, or the platelet level below 100,000. We have treated three patients with myeloid leukemia, three with lymphoid leukemia, and one with monocytoid leukemia by replacement transfusions—administering with pumps 10 pints of compatible blood and removing 9 pints during a two-hour period. Clinical improvement lasted for only 6 to 48 hours. We have had no satisfactory remissions, as have been reported by other authors,^{14, 15, 16} after administration of either single transfusions or exchange transfusions. Antibiotics (aureomycin, penicillin, streptomycin, terramycin, etc.) are indicated specifically when infections are associated with leukemia or to prevent secondary infections.¹⁷ Antihemorrhagic agents (vitamin K, antihemophiliac globulin, adrenoxyl, protamine, toluidin blue) are indicated when specifically needed.

Inhibitory agents: The older inhibitory agents which have been used extensively in leukemia, such as arsenic and x-radiation, will be only briefly mentioned. The newer agents, most of which are no better than the older medications, will be emphasized. Because the basal metabolic rates of patients with leukemia are usually elevated, both thyroidectomy¹⁸ and antithyroid drugs such as thiouracil¹⁹ have been used as treatment, but have not significantly altered the course of the leukemic process. Attempts to inhibit the mitosis of leukemic cells by colchicine have been made.²⁰ Doses of 0.5 mg., three times a day, are given orally but no lasting remissions have resulted. Various enzyme inhibitors such as sodium fluoride, iodo-acetic acid, sodium oxide, and malonic acid have been used, but their use did not change the ultimate course of the leukemic process in patients.

Heavy metals, which are also enzyme inhibitors, have been used for years. Both arsenic (Fowler's solution) and lead²¹ can cause temporary remissions. BAL (British anti-lewisite)

can inhibit the effectiveness of arsenic. BAL was given to one patient with myeloid leukemia after he had had a satisfactory remission with Fowler's solution and immediately a relapse occurred. In a subsequent four-day period, additional quantities of Fowler's solution again lowered the white cell level to as low as 1000/ cu. mm., but in the following equal period of time BAL was again administered and the white cell level rose to 100,000/ cu. mm. a second time. This sequence of events was repeated three times.

After Isaacs* reported that tyrosinase produced remissions in leukemia, we gave it to 2 patients with leukemia (1 myeloid and 1 lymphoid) without noting any change in the white cell levels. We have given another enzyme, cytochrome C (100 mg. intramuscularly, daily), to three patients with lymphoid and one with myeloid leukemia, and all four of the patients became clinically worse: and the white cell levels rose sharply.† We have treated with alpha hydroxyheptane sulfonate (50 to 100 mg. intravenously, daily) one patient with myeloid, two with lymphoid, and one with monocytoid leukemia without noticeable changes in the white cell levels or the clinical course.

Since 1946 we²² have used nitrogen mustard (methyl-bis beta chloroethylamine)‡ in 36 cases of leukemia (10 myeloid, 18 lymphoid, 6 monocytoid, and 2 eosinophiloid). A course of treatment consists of a daily intravenous injection for four days, the daily dose varying from 4 to 10 mg. From our experience, nitrogen mustard should not be used in acute leukemia nor in monocytoid or eosinophiloid leukemia. Of the chronic types, it seems to be more effective in reducing lymphadenopathy and lowering the white cell levels in lymphoid than in myeloid leukemia. The remissions do not last as long as those following x-radiation, but nitrogen mustard is cheaper, more easily administered, and is now on the market as mechlorethamine hydrochloride.

We have administered an "oral type of nitrogen mustard" (tri-ethylene melamine**—T.E.M.) to 15 cases of leukemia (6 myeloid, 8 lymphoid, and 1 eosinophiloid). A dose of 5 mg. one hour before breakfast was orally admin-

* ABS: Proc. Fed. Am. Soc. Exp. Biol., 6: 394, 1947.

† We have given cytochrome C to 3 patients with agranulocytosis, two of whom had complete remissions; the other patient died.

‡ Furnished by Merek & Co., Inc., through the courtesy of The National Research Council.

** Furnished by Dr. J. M. Rueggesser of Lederle Laboratories through the courtesy of the National Research Council.

istered for either two or three days. We had believed that T.E.M. was more effective for those leukemic patients with hepatosplenomegaly since T.E.M. is absorbed directly from the intestinal tract, while nitrogen mustard given intravenously could more readily attack the marrow and mediastinal lymphadenopathy. However, we had two patients with chronic lymphoid leukemia with huge cervical lymphadenopathy which essentially disappeared following 5 mg. of T.E.M. orally daily for three days. Both nitro-

gen mustard and T. E. M. seem to make leukemic infiltrated tissues respond more effectively to x-radiation, and vice versa. T.E.M. alternated with radioactive phosphorus has also been an efficient method of maintaining prolonged remissions in cases of myeloid leukemia.

Since 1946 we have also administered urethane to 35 cases of leukemia (18 myeloid, 14 lymphoid, and 3 monocytoid) and, as have others,²³ we find it most effective in cases of chronic myeloid leukemia. Urethane is given in 1 or 2 gram

TABLE III

Present-day therapeutic leukemic agents listed according to our choice including dosage and duration of remission following such therapy. Combinations of therapeutic agents sometimes are preferable, such as giving T.E.M. which apparently increases the sensitivity of leukemic cells to later irradiation such as P-32. P-32—radioactive phosphorus; HN₂—nitrogen mustard; T.E.M.—triethylene melamine; ACTH—adrenocorticotrophic hormone. All dosages depend upon leukocyte levels and clinical responsiveness.

Treatment				
Type of Leukemia		First Choice	Second Choice	Third Choice
Myeloid leukemia	a. Acute App.* dosage	Lymphokentric acid undetermined	Urethane 1 gram daily	Yeast (brewers') 20 to 100—5 gr. tablets daily
	App. remission	3 to 6 months	1 to 3 months	1 to 3 months
	b. Chronic	Radioactive phosphorus	Urethane	(1) T.E.M., 5 mg. orally for 3 days
	App. dosage	5 millicuries every 4 months	1 gram daily (depending on w.b.c. level)	(2) X-radiation
	App. remission	1 to 9 years	6 months to 4 years	(3) HN ₂
Lymphoid leukemia	a. Acute App. dosage	Cortisone 300 to 2000 mg. in 10 days	Aminopterin 1 mg. daily (intra- venously or orally)	ACTH 40-80 mg. daily for 10 to 20 days
	App. remission	1 to 6 months	1 to 3 months	1 to 2 months
	b. Chronic	Radioactive phosphorus	HN ₂ (repeat courses every six months)	(1) T.E.M., 5 mg. daily for 3 days—a course.
	App. dosage	5 millicuries every 4 months	20-30 mg. over a 4-day period	Repeat depending upon w.b.c. levels
	App. remission	1 to 7 years	1 to 4 years	(2) X-radiation
Monocytoid leukemia	a. Acute App. dosage	Yeast (brewers') 20 to 100—5 gr. tablets	Cortisone 300 to 2000 mg. in 10 days	ACTH 40-80 mg. daily for 10-20 days
	App. remission	1 to 3 months	1 to 2 months	1 to 2 months
	b. Chronic App. dosage	Yeast (brewers') Same	Same as acute	Same as acute
	App. remission			
Eosinophilic leukemia	a. Acute	None	.....	.....
	b. Chronic	X-radiation	Cortisone	ACTH
Plasma cell leukemia (Multiple myeloma)	a. Acute	ACTH	Cortisone	Urethane
	b. Chronic	ACTH	Urethane	Cortisone

* App.—Approximate

doses daily, orally. It is very cheap and it is available. It apparently interferes with various cellular dehydrogenase systems.

We have not used benzol, carcinogens,²⁴ or bacterial polysaccharides,²⁵ nor have these agents been administered with any startling therapeutic effectiveness. Nor have we used R⁴⁸ (B-naphthyl-di-2-chloroethylamine),²⁶ which is about equal in effectiveness to T.E.M. The radiations used for leukemia should be divided into x-rays, neutron rays, and radioisotopes—*radiophosphorus* (P³²—14.5 day half-life—a pure beta ray emitter), *radiosodium* (Na²³—14.8 hour half-life—both a beta and gamma ray emitter), and *radio-gold* (Au-¹⁹⁸—2.7 day half-life—both a beta and gamma ray emitter). Radiations cause intracellular ionization which can inhibit enzymes, denature proteins, alter genes, etc., but none have cured leukemia. Since x-rays can be directed, they are useful for treating localized areas such as mediastinal lymphadenopathy, splenomegaly, etc. However, we have had four patients with chronic leukemia who responded to x-radiation therapy by the rapid enlargement of mediastinal glands and cervical nodes. Each of the four, however, responded satisfactorily to nitrogen mustard or tri-ethylene melamine, which were given later.

X-radiation, like other anti-cancer agents, may fail occasionally in the very cases and in the very conditions in which x-radiations usually are indicated. X-radiation therapy will not be discussed here, since it has been used for 50 years, except to say that it can be used in conjunction with or alternated with the other therapeutic agents mentioned. Neutron rays are still extremely expensive and apparently have no advantage over x-radiation.²⁷ We have used radioactive phosphorus for more than 12 years (since 1938)²⁷ in chronic types of leukemia. We have treated 55 cases with P³² obtained from the Atomic Energy Commission (29 myeloid, 20 lymphoid, and 6 monocytoid; in addition to 100 cases reported in 1941). During the past decade well over 1000 cases of leukemia have been treated throughout the United States with P³², which is cheap, available,* easily administered, and does not cause radiation sickness. P³² inhibits mitosis in prophase. Like all radiations, P³² should be given only to cases of chronic leukemia. The dosage usually varies from 5 to 15 millicuries during the first 90 days and about

15 to 30 millicuries yearly thereafter. Since radiosodium²⁸ and radiogold²⁹ are gamma-ray emitters, they are much more difficult to administer and they are more expensive than P³². They have no advantage over P³²; and Na²³ has a very unsatisfactory short half-life. (Radioarsenic and radiomanganese have been used in a few cases of leukemia without significant advantage.)

Stimulative agents: Many agents have been used to stimulate or mature leukemic cells to a stage where the bodily processes could control the growth of these cells. Bone marrow extracts were used by Cooke.³⁰ Splenic extracts³¹ have been used. Extracts of the reticulo-endothelial system³² and even extracts of amebae (*Trypanosoma cruzi*) have been tried. More recently extracts of the pituitary and adrenal glands have been used. We have given various quantities of ACTH † (adrenocorticotrophic hormone) in 11 cases of leukemia (2 myeloid, 7 lymphoid, 1 monocytoid, and 1 eosinophiloid). We have noted short remissions of one to four weeks, but the remission cannot be repeated with additional quantities of ACTH. We have also treated 8 cases (2 myeloid and 6 lymphoid leukemia) with cortisone ‡ with the same rather unsatisfactory results.³³ Although the therapeutic value of ACTH and cortisone is limited in leukemia, their effects may well help in solving the etiology of leukemia.

We administered extracts of adrenal glands (lipo-adrenal **) to 5 cases of lymphoid leukemia. In each case there was a short, mild incomplete remission of one to four weeks' duration. It was administered in the hope that a significant lysis of the lymphoid cells might occur.³⁴ Recently, Miller and associates^{35, 36} have been extracting, from the urine of leukemic patients, steroids which apparently specifically stimulate and mature either lymphoid or myeloid cells. *Lymphokentric acid* stimulates lymphopoiesis but matures myeloid cells, while *myelokentric acid* stimulates myelopoiesis but matures lymphoid cells. These agents are often followed by temporary remissions of the acute leukemic process. None of the numerous extracts mentioned above have cured leukemia, however.

Tubercle bacilli which contain various fats

† Obtained from Dr. J. R. Mote, Armour Laboratories, Chicago, Ill., and from United Research Laboratories, Inc., Philadelphia, Pa.

‡ Obtained from Dr. J. M. Carlisle, Merck & Co., Inc., Rahway, N. J.

** Obtained from Dr. H. F. Hailman, Upjohn Co., Kalamazoo, Mich.

* Available from Atomic Energy Commission, Oak Ridge, Tenn. (Dr. Paul Achersold), or from the Abbott Laboratories, North Chicago, Ill. (Dr. D. L. Tabern).

and sterols may be associated with leukemoid reactions,³⁷ but the tuberculous process can also depress the leukemic process.³⁸ Large quantities of yeast have been administered to patients with leukemia in the hope that such fungi might contain maturing substances for leukemic cells. On the whole, leukemic patients can tolerate large doses of brewers' yeast (100 tablets daily) better than individuals without leukemia. In chronic types of leukemia, yeast seems to supply additional nourishment (nucleoproteins or even conjugating substances) for the body, or adds maturing substances for the leukemic cells. However, in a few cases of leukemia, especially the acute form, yeast may supply a type of folic acid which may unfortunately stimulate the growth of the leukemic cells. Further research on isolation of leukocyte maturing substances from yeast might well lead to important information.

Competitive agents: These agents are used in an attempt to utilize or destroy the nutrients required by the leukemic cells for growth. For example, folic acid is a nutrient needed by most cells. Leukemic cells, since they grow rapidly, should require more folic acid than normal cells. It would appear then that anti-folic acid agents would inhibit the growth of leukemic cells more effectively than normal cells. We have used such anti-folic agents as diopterine, teropterine, A-methopterine, and aminopterine.* We gave diopterine to 1 case of myeloid leukemia, 12 lymphoid, and 1 monocytoid. None had significant remissions. We gave A-methopterine to 5 cases (1 myeloid, 3 lymphoid, and 1 monocytoid), none of which had remissions. Teropterine was given to 10 cases (1 myeloid, 5 lymphoid, 2 eosinophiloid, and 2 monocytoid), none of which had lasting remissions; in fact, 2 patients definitely became worse. One 25-year-old male, with myeloid leukemia, was given teropterine (20 mg. intramuscularly, daily for four days) and his white cell level rose from 1000 to 100,000/cu. mm. He was then given aminopterine (1 mg. daily intramuscularly for three days) and the white cell level fell again to 1000. This sequence of events was repeated on three occasions, illustrating the antagonistic reactions of these two drugs in this particular patient with myeloid leukemic cells.

Aminopterine was administered to 26 of our patients with leukemia. We have reached the

same conclusions as most other investigators³⁹ that aminopterine is most effective in acute lymphoid leukemia of childhood. Remissions may last from one week to six months in about 25 to 35 per cent of the patients. Aminopterine is often followed by hemorrhages from the nose, gums, and bowels (particularly from ulcerations of the ileocecal area), fever, anorexia, loss of body hair, nausea, and abdominal pain. Aminopterine may be given intramuscularly or orally in 1 mg. dosages daily. The oral administration is preferred in patients who have leukemic infiltrations primarily of the abdominal organs.

Another competitive agent is *para-aminobenzoic acid*. Some investigators⁴⁰ have noted reductions in the white cell levels following its administration. We, as have others,⁴¹ have noted elevations of the white cell levels with worsening of the patient's clinical course when PABA was given. Other competitive agents are various disease-producing viruses.

In Table I are listed 12 patients who had complete or near complete remissions of their leukemic process for from four months to nine years. Except for 3 cases, all had some virus disease as an apparent initiating factor for their remission. Because of that experience, we gave dengue virus* to 5 patients with leukemia (1 myeloid, 3 lymphoid, 1 monocytoid) and rickettsial pox virus† to 2 cases (1 myeloid and 1 lymphoid), but none had a significant remission.‡ We used the two above-mentioned viruses because the mortality rate is practically nil in both. Rickettsial pox is associated with petechial hemorrhages, and one of the patients who received this virus died of a cerebral hemorrhage.

Shimkin** also has administered such viruses as lymphopathia venereum and Rocky Mountain spotted fever to patients with malignant diseases including leukemia. Some of his patients had short remissions.

Discussion

The incidence of leukemia—an invariably fatal process at present—is increasing. The cause is unknown. The fundamental causes might be listed as:

1. Deficiency of specific maturing sub-

* Obtained from Dr. Albert Sabin, University of Cincinnati, Cincinnati, Ohio.

† Obtained from Dr. Harry M. Rose, Columbia University, New York City.

‡ ERF, L. A.: Discussed at the First National Cancer Conference, Memphis, Tenn., Feb. 25, 26 and 27, 1949.

** SHIMKIN, M. B.: Reported at the Fifth International Cancer Research Congress, Paris, 1950.

* All of these substances were furnished by Dr. S. M. Hargraves, Lederle Laboratories, Pearl River, N. Y.

stances for reticulo-endothelial cells or their progeny.⁴²

2. Deficiency of enzymes, vitamins, or hormones for various intermediate cells.
3. Deficiency of conjugating substances which prevent accumulations of intracellular wastes.

Some of the initiating causes might be listed as:

1. Increased chemical exposures to manufacturing plant wastes which exist in the air and in drinking water, to benzol products as gasoline fumes, etc.
2. Increased drug exposure such as aspirin, sulfa drugs, tobacco, mineral oil, and perfumes.
3. Increased radiation exposure such as x-radiation, radioactive agents in crude oil products, and even sunlight.
4. Increased emotional exposure⁴³ which may cause rapid utilization of intracellular nutrients, alter hormonal balances, etc.

The treatment of leukemia has been approached by using agents which (1) inhibit enzymes, (2) arrest mitosis, (3) compete for metabolites or nutrients, (4) stimulate cell metabolism or inhibit it, and (5) sustain cellular life.

Most of the nearly 50 therapeutic agents discussed in the text will usually cause various degrees of remission indicating some common denominator. An attempt has been made to classify some of the recently used therapeutic agents (Table II) and to arrange them according to effectiveness in light of present-day knowledge (Table III). Combinations of these agents, since each has a more or less specific function, should be used for prolonging the life of a leukemic patient. X-radiation,⁴⁴ although not emphasized, should be used in combination with other agents when indicated. The Heublein technique,⁴⁵ which is a type of irradiation similar to radiophosphorus, is preferred. Splenectomy is contraindicated in patients with leukemia except when complicated with hemolytic anemia. Exacerbations of leukemia usually occur more frequently and profoundly after splenectomy. No known case of leukemia has ever been cured. So far, the cases reported as cured were cases of (1) infectious mononucleosis, (2) leukemoid reactions, and (3) prolonged spontaneous remissions of leukemia (see Table I). It is doubtful if

any treatment consistently alters the fundamental progressiveness of leukemia, but most patients are made more comfortable after the use of some of the therapeutic agents mentioned.

Since complete remissions of leukemia have spontaneously occurred (for various periods of time) and since leukemoid reactions (indistinguishable from leukemia) have completely disappeared, it is possible that leukemia can and will be controlled in the near future when more knowledge is available.

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WHAT ABOUT HEARING AIDS?

The electric hearing aid has been in use for about twenty-five years, but because of constant improvements in appearance, weight, and efficiency, together with extensive press and radio advertising, its popularity is increasing by leaps and bounds. Therefore, the sensible deafened person has ceased to consider it a stigma to wear one, and he is no longer the object of curious stares. Indeed, whereas in 1935 the otologist had to use all his powers of persuasion to convert the patient to the idea of wearing the then cumbersome and unsightly contraption, now, in 1950, he spends almost as much time trying to dissuade a patient whose case is unsuitable from buying one.

Of course, there is some advantage in using a hearing aid, even though there be little or no real improvement in hearing, because it says to all who see it what the average deaf person is so loath to admit, "I am deaf. Please speak distinctly, and a little louder." This is the very reason why much of the current advertising and trends in manufacture seem of questionable value to the writer. All are aimed at concealing the earpiece and thus the defect in hearing. This concealment, which seems such an integral part of the psychology of deafness, is regrettable. When one wears glasses he announces to the world that his vision is less than normal. Why is it that ninety-nine out of a hundred whose hearing is less than normal use every effort to conceal it? By so doing they are under constant nervous tension in group conversation; and both at work and socially they are often considered inattentive, rude, or mentally slow. A frank admission of the defect is always wise.

The electric hearing aid consists of a microphone, through which the sound enters, to be carried to the amplifier, consisting chiefly of vacuum tube and battery. The amplified sound is then carried along a wire to the earpiece, which usually has been moulded to fit the patient's ear. The bone conduction type is worn over the

mastoid process. The early earpiece was a receiver on a head band, similar to those worn by telephone operators. Then came the black moulded earpiece. Now most models have a clear lucite or flesh-colored earpiece and wire which are quite inconspicuous. The early amplifiers and batteries were very cumbersome, compared with present models.

A properly fitted and efficiently operating hearing aid is a great blessing to a deafened individual but, in order to prevent disappointment, he must realize that, after all, it only amplifies sound, and cannot replace a degenerated auditory nerve. Accordingly, in marked perceptive or nerve deafness, no hearing aid can be expected to give very good results. The best results are found in cases of otosclerosis or other types of conductive deafness.

Many errors are made in buying and in selling hearing aids. The eager-to-hear patient and the overzealous salesman sometimes combine to negotiate a too hasty sale. It is poor economy, frequently practiced, for one to buy a hearing aid without first having an otologic examination and advice. That is self-evident to readers of this *Journal*, but they would be astonished to know how many go shopping for an aid as they might for a pair of shoes, with no better recommendation than an attractive advertisement, a dulcet-voiced radio announcer, or the assurance of a neighbor that a friend hears perfectly with a certain model.

A prospective buyer may be advised by writing to the American Medical Association whether or not any model is on its approved list. This list in February, 1949, included some sixty models manufactured by twenty-seven companies. Most reliable companies will rent an aid for a before-purchase trial. Unfortunately, there are many unapproved and worthless so-called hearing aids on the market. Indeed, there are very few occasions when the good old law of *caveat emptor* will be more useful.—ALICE K. HALL, M.D., *Journal of the American Medical Women's Association*.

An Experiment in the Maintenance of Positive Health

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THE MODERN concept denies the fallacious definition that "health is the maximum absence of disease." Let us rather consider health as a condition of the human body in which the functions are acting at their physiologic optimum. This approach assumes that a state of balance exists between all physiologic and psychologic processes and those forces (heredity, nutrition, exogenous chemical agents, physical forces, micro-organisms and psychobiologic influences) which act to upset this balance. When a state of equilibrium exists between these two opposing conditions, then the person may be said to be in a state of positive health.

The advances of modern science are focused on the discovery of all these health-opposing factors. Gradually the nature of these agents is being discovered and many of the causes which act to sabotage health are either controlled, modified, or removed. It follows logically that since all the causes of non-health are known or knowable, then disease (which is one or a combination of forces acting to upset the state of positive health) is not inevitable. Disease is not inevitable; if it has an ending, so must it have a beginning. Disease can develop only when those conditions are present which allow this state to exist.

It is the recognition of the beginning of disease processes which is the challenge to medicine today. In this twilight zone of the presymptomatic or so-called preclinical, modern clinical preventive medicine can do so much for the maintenance of positive health.

Periodic examinations of apparently well persons have been practiced successfully by pediatricians and dentists for some time. However, while the examination of well adults for the purposes of maintaining health is advocated, it is not practiced to the extent that is warranted by the

benefits of such a procedure to individual and community health.

Material and Methods

The periodic examination of well adults (over 12 years of age) for the purpose of maintaining them in a state of health, rather than treating them when they are sick, was started in 1948 at the Health Maintenance Clinic of the Fife-Hamill Memorial Health Center. This is a unique service and inaugurates what is possibly the only clinic of its kind in the United States. In contradistinction to clinics directed primarily for the *detection* of cancer, tuberculosis, heart disease, etc., the Health Maintenance Clinic practices polyphasic screening, that is, attention is devoted not only to the *detection* of disease but a complete evaluation is given to *all* those factors which operate to upset the balance of health.

The basis of this program is periodic history taking and physical examination at individualized specified times during the year. The intervals between re-checks are determined not by the patient's awareness of such necessity when a specific complaint appears, but on the physician's judgment based on his knowledge of the individual's peculiar physical and mental make-up, environment, and hereditary proclivities.

In the Health Maintenance Clinic, senior medical students, the physicians of tomorrow, are taught the technique of uncovering pertinent and suggestive facts from the patient's history. By careful, painstaking physical examinations early departures from the "physiologic normal" are discovered. Students are made aware of environmental, psychic, and social factors which tincture not only the patient's story but are definitely reflected in his or her psychosomatic and present health status.

The primary purpose of the history, therefore, is to uncover the existence in the individual or his environment of factors which predispose to

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imbalance health; if these conditions are permitted to continue unchecked, a *definite* disease state would eventuate.

The physical examination comprises an examination of the entire body according to the recognized principles of physical diagnosis.

Every departure from the normal that may be discovered becomes a signpost directing the physician toward hidden or overt causes that *must* be responsible for the development of the abnormal condition.

Included are a neurologic survey and, in women, a Papanicolaou smear and cervical (scraping) surface biopsy. Routine laboratory studies on each patient consist of a complete blood count (hemoglobin, red blood cells, white blood cells, and differential and sickling trait in negroes), blood serologic test, routine urinalysis, stool examination for parasites and ova, sedimentation rate, and photofluoroscopic x-ray of chest.

If the history and physical examination indi-

cate the need for further laboratory study, these are done either in the health center or referred to the proper department in one or more hospitals.

When all the data on the individual are assembled, the student and a member of the staff discuss the entire situation. If no apparent deviation from the normal range of health is discovered, the patient is given a return appointment for a re-check varying from six months to one year. Evaluation of the patient's history and physical examination centers on the attempt to elicit existing or potential causes of disease that can be obstructed, removed, or accentuated by the application of the principles of prevention.

If, however, some defect or disease is discovered, the patient is referred either to his private physician or to a hospital clinic of his choice. In this event, even though the patient is under treatment at one of these sources, he still returns to the Health Maintenance Clinic for peri-

DISTRIBUTION OF DISEASES OR SYNDROMES FOUND IN 623 PATIENTS

<i>Ages</i>	<i>12-20</i>	<i>20-30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>
Anxiety state	3	33	55	22	6	2
Caries of teeth	12	45	41	15	4	1
Cervical erosion and endocervicitis ..	..	42	61	16	3	..
Cervical polyp	..	1	3	1	1	..
Cystocele	..	22	39	18	6	..
Diabetes	..	..	..	2	5	..
Fibroma	..	1	1	1	1	..
Goiter	1	3	7	3	1	..
Hypertension	1	5	7	12	10	3
Hypochromic anemia	11	33	45	15	4	..
Malnutrition	9	16	10	9	1	1
Obesity	11	33	61	..	25	18
Ovarian cyst	..	..	1	..	..	..
Pregnancy	..	7	14	..	..	..
Rectocele	..	18	27	18	7	..
History or signs of rheumatic fever	5	15	3	3	..	..
Syphilis	2	4	6	4	1	..
Tuberculosis	..	..	1	3	..	..
Valvular heart disease	2	10	7	3	..	1

odic checkups and interval consultation and health suggestions.

In a program such as this, which gives complete health guidance, a number of other agencies and bureaus are consulted. Among these may be listed the public health service of the Fife-Hamill Memorial Health Center, the Henry Phipps Institute, Family Service of Philadelphia, Legal Aid Society, Department of Public Assistance, Social Service Exchange, Society to Protect Children, Board of Education, Philadelphia Department of Health, vacation bureaus, etc.

Results

This report analyzes the findings of 623 patients; of these, 426 were white females, 116 negro females; 71 white males and 10 negro males.

In a series of 623 patients, only 18 were found who had no physical abnormalities which required correction. One of these deviations from the normal may have been only a carious tooth. This severe criterion was established to give factual proof of the imperative need for a program of health conservation and maintenance.

Papanicolaou smears and cervical scrapings were made on 333 women (61 per cent of the female clients). One patient with a suspicious smear was later proved at biopsy to have carcinoma of the cervix.

Other disease states were distributed as seen in the table.

Conclusions

A program for health maintenance based on periodic physical examinations is a necessity for

the maintenance of a state of positive health and the early detection and correction of disease.

Such a procedure can be made either in organized clinics or more practically for the great middle class of clients in practitioners' offices. Private physicians, if they have the awareness of positive health, can do more for their patients by trying to keep them healthy than in attempting to cure them when they are ill.

The response which has greeted the efforts of the Health Maintenance Clinic proves beyond doubt that the public is ready for such a program. Physicians must keep abreast if not ahead of the trend and lose their apathy concerning the conservation of health.

Summary

1. Health is a state of balance between optimum physiologic and psychologic functions and opposing forces and agents which tend to disturb this equilibrium.

2. Periodic health examination by polyphasic screening offers the best assurance for the maintenance of health and the early, correctable detection of disease.

3. This program is a vital part of the medical student's curriculum. As future physicians these young men must become aware of the medicine of tomorrow.

4. In 623 patients only 18 (2.9 per cent) were completely without physical defects.

5. Certain disease entities were discovered in this survey (see table).



Diagnosis and Non-operative Treatment of Low Back Pain

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PAIN IN the lower part of the back can be divided into three main categories—acute, sub-acute, and chronic. Frequently in the acute cases a definite diagnosis is impossible. The examiner is only able to tell that the patient suffers from an underlying pathologic condition and can most often localize it in the spine or sacro-iliac joints. The fact that a patient has such pain is indicated by his stance, in that he might be limping or bent over, or he rises with great difficulty from a sitting position. Other signs of acute irritation are muscle spasm of the lumbar, iliacus, or hamstring muscles. Spasm of the erector spinae might cause the patient to list to one side and be completely limited in motion when putting the involved spastic muscles on tension. Frequently, spasm may cause a complete loss of the normal lumbar curve and the patient may walk bent forward. In such cases of acute backache with spasm and deformity, further diagnostic evaluation should be made in the hospital with the use of such aids as x-rays, blood count, sedimentation rate, a trial period of complete bed rest, and perhaps an intravenous injection of tolserol. Quite frequently in these acute cases of back pain, the x-rays are negative and one then comes to the conclusion that he is dealing with an acute irritation of the muscles or ligaments in the area involved.

The subacute cases are easier to examine in that they are not rigid with acute pain and there is less muscle spasm. Here, again, one may not be able to make a definite diagnosis as to the cause of the complaint, but can frequently localize the condition and with the further aid of x-rays make a definite diagnosis. The patient is examined standing without clothes, with the exception of a draped sheet on a woman or a pair of shorts on a man, and is made to walk and stand with the back toward the examiner. The condition of the feet should be noted, as fre-

quently a backache may be the result of continued foot strain. The back is then noted as to whether the various spinal segments can be carried through the normal range of motion. Rotation occurs primarily in the lower dorsal region. Lateral bending, flexion, and extension occur in the lumbar region. On carrying the patient through these manipulations it may be noted that motion is occurring in the high lumbar region while the lower lumbar and lumbosacral segments are fixed. The patient is then examined sitting on the side of a table.

A spine that is limited in forward bending in a standing position may be free in a sitting position. In such a case one is led to believe that the restriction of motion while standing is due to a hamstring spasm and not due to a pathologic condition in the lumbar spine, for in the sitting position the hamstring muscles are relaxed. It therefore follows that a patient limited in forward bending, both sitting and standing, should have an existing pathologic condition in the lumbar spine. The patient is then made to lie on his back and the legs are measured to determine any possible inequality. In measuring each leg from its anterosuperior spine to the internal malleolus, one obtains an actual measurement of the length of the leg itself. When measuring each leg from the umbilicus, providing the actual length of the legs is equal, one can pick up an apparent discrepancy in leg length which is due to a pelvic tilt or a low lumbar scoliosis. Obvious pelvic tilt and scoliosis should be discernible to the examiner when the patient is standing. With the patient lying on his back, the straight leg raising test is carried out and a normal leg should easily be brought up to right angles with the table. However, in cases of hamstring spasm or contracture, the straight leg raising test is limited. During the straight leg raising test the foot can be forcibly dorsiflexed and, if sciatic pain is involved in the condition, it can be reproduced by this test which is known as Lasègue's sign.

Read before the Section on Surgery at the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 18, 1950.

Another valuable test is the forcible flexion of the thigh upon the abdomen which, if there is sacro-iliac irritation, will cause pain when the flexion of the thigh passes beyond the normal range of hip joint motion. This is known as Gaenslen's sign. Reflexes, both knee jerks and tendo Achillis, should be elicited, for with nerve root irritation due to edema around the foramen of the vertebrae or pressure from a ruptured intervertebral disk or cord tumor, reflexes such as the tendo Achillis jerk may be missing. The patient should be tested for sensation by pinprick around the various segments of nerve root supply to the lower extremities. Paresthesias are common in cord tumors or herniated disks. A not uncommon finding in herniation of a disk is weakness of dorsiflexion of the big toe. Also, while the patient is lying on his back, the examiner should examine along the inner aspect of the ilia for any spasm or thickening of the iliacus muscles. The patient is then turned over on his abdomen and the spine examined by palpation and percussion. A spondylolisthesis may often be palpable both standing and lying. Localized tenderness over the lumbosacral or sacro-iliac joint can often be detected by these two procedures. While on his abdomen the patient should be tested for psoas spasm by hyperextension of the legs on the pelvis.

In chronic cases, perhaps one or only a few of the afore-mentioned signs may be obtained and very frequently nothing can be found at the time of the original examination. However, in cases of chronic osteo-arthritis, limitation of motion in the spine is nearly always present.

History is of the utmost importance. One should know the duration of symptoms and whether the condition was of sudden or gradual onset. One should know whether there had been an accident or injury at any time which might be directly or remotely responsible for the complaints. One should know whether the pain radiates along the course of nerve distribution. The examiner should ask what motions bring about the pain such as stooping, bending, and lifting, whether the patient is stiff in the morning on rising, and whether the symptoms are affected by weather changes. These last two are common complaints in arthritis cases. In cases of ruptured intervertebral disk, intermittency of symptoms and attacks with radiating pain, paresthesias, and a lateral list are the most frequent symptoms. The examiner should know what positions relieve the patient's symptoms and

what positions he might get in to aggravate the symptoms. He should be asked if jarring such as riding in an automobile causes difficulty.

So we have innumerable characteristic symptoms from the history and signs by physical examination which help us to come to a diagnosis, always remembering that perhaps we are not able, without further study, to make a definite diagnosis. Many times the orthopedic specialist feels that he knows less and less about low back pain and is frequently in a quandary as to its cause and origin. However, given a patient with a history of pain originating in the back of the left hip, worse on standing and walking and relieved by lying down, radiating perhaps into the hip joint region and the back of the thigh, who presents a positive Gaenslen's sign and is tender on palpation and percussion over the sacro-iliac and whose forward bending is free on sitting and restricted on standing, one can localize the pain to the sacro-iliac joint. If, in his history, he is stiff in the morning on rising and changes of weather such as dampness aggravate the situation, one can feel that he probably has an arthritis involving the sacro-iliac. Given a patient with pain across the low part of the back radiating to both hips, no stiffness in the morning, worse on motion and activity, and presenting bilateral hamstring spasm and lumbosacral sensitivity by palpation, one can suspect some structural lesion of the lumbosacral region such as a spondylolisthesis, an unstable vertebra, or a deformity, either congenital or acquired.

X-rays, of course, are essential in the compilation of all facts relative to low back pain. One should know whether any focus of infection is an irritating factor in such conditions as fibromyositis and intervertebral arthritis. We have not given up considering foci of infection as a possible source of irritation. In females the gynecologic and urinary systems are often guilty of referred pain to the lower part of the back. In males the genito-urinary system is a frequent offender. In those cases with no obvious spinal deformity, spasm, or limitation of motion, these other systems should be thoroughly investigated. The gallbladder, pancreas, etc., are not infrequently the cause of pain through to the back.

Strain can be diagnosed by symptoms more localized to definite muscle groups and the pain of such strain should be elicited by putting the involved muscles on tension such as active hyperextension.

When origins other than the musculoskeletal

systems have been eliminated and the patient complains of mild low back pain without existing deformity, conservative ambulatory measures may be adequate to bring about relief. In cases of mild muscular strain, heat and massage and regulated exercises of involved muscle groups for correction of the strain may be adequate. Such patients should be instructed in methods of eliminating strain by postural correction and education in body mechanics. Strain from a constantly poor posture during working hours should be considered. Too often a soft mattress allowing flattening of the normal lumbar curve will be responsible for back pain, but correction can be obtained by placing boards between the mattress and the spring or changing the patient to a hard bed.

In cases of severe strain or sprain, it might be necessary to put the muscle group at rest for a period of healing, and this can be done temporarily by adhesive strapping or by fitting the patient with an adequate support. This should be accompanied by physical therapy, and when the symptoms have subsided, exercises as previously mentioned should be instituted. In an older group many of these patients show early irritative changes around the joints by x-ray and examination reveals some muscular spasm. Such cases frequently respond to a properly fitted support together with physiotherapeutic measures.

In more advanced cases of proliferative or hypertrophic joint changes, or in cases of ruptured intervertebral disk associated with some deformity and muscle spasm, hospitalization is necessary. Many of these cases have accompanying nerve root pain radiating along the sciatic or other branches of the lumbosacral plexus. Muscle spasm may be responsible for a list to one side or a flattening of the lumbar curve. Spinal segments are limited. For such cases in which it is felt that ambulatory treatment would be of no avail, hospital treatment of complete bed rest together with other measures is essential. It is necessary that bed rest be complete, allowing no bathroom privileges and no sitting up in bed. Too often physiologic bed rest is not strictly enforced. In such cases the bed must be firm, allowing no sag, and we believe that the normal physiologic position of the spine, restoring or maintaining a normal lumbar curve, is essential. A lumbar pad made of folded sheets is frequently of benefit. There are some who feel that bed rest in a position of flexion of the spine in some pathologic conditions is the procedure of choice. We

have been unable to agree with this train of thought.

In those patients with referred leg pain, traction to the involved leg during the period of bed rest frequently, and often immediately, relieves the referred pain. There are some cases, however, which do not respond to the above procedures. It usually requires at least five days to determine whether the instituted treatment will be of benefit, for all of these cases, in the first four or five days, are troubled with considerable constipation, even to the point of a mild ileus, and this is accompanied by abdominal pain and pain from strain on certain muscle groups due to the position. For this reason, it is advisable to start immediately on catharsis and enemas and the use of prostigmine in an effort to combat this difficult period.

Recent work reported at the January session of the American Academy of Orthopedic Surgeons has stimulated the use of tolserol intravenously as a diagnostic and treatment procedure. One vial contains 100 cc. or 20 mg. and is given fairly rapidly over a period of 10 to 15 minutes. This apparently has the effect of relieving severe muscle spasm and is being used in various parts of the country as a test to indicate the advisability of continuing with conservative measures or resorting to more drastic operative procedures. It has been found particularly helpful in cases of ruptured intervertebral disk. After the administration of tolserol, if muscle spasm has been overcome to the point that straight leg raising is free and pain is eliminated, it is considered advisable to continue with conservative therapy, perhaps repeating the use of tolserol at daily intervals for three to four days. If, however, the tolserol does not relieve the pain and spasm, the case must be considered as one of great doubt for the efficacy of conservative therapy. The drug is given to the point where active nystagmus is obtained.

Procaine hydrochloride given intravenously, one gram per 500 cc. (two-tenths of 1 per cent) of normal saline solution, is frequently of benefit and apparently works through the synapses breaking the reflex arc and controlling pain. When this does work, it is possible to institute earlier and more active physiotherapeutic measures. The drug is given daily over a period of an hour and should have four or five days' trial before estimating its value in the individual case.

Recently a drug, Tubadil, made by Endo, which is a tubocurare, has been placed on the

market for the relief of acute muscle spasm. This drug has been processed in an effort to make the effects less dangerous and more prolonged than those of curare. I have had no experience with the drug as yet to report the results of its effect. Tolzem is another such drug, put out by Zenmer. I suspect it is some form of tolserol, but have had no experience with it. In cases of arthritis, if truly rheumatoid in type, and if not well controlled by other conservative methods, we have had no hesitation, under medical supervision, in trying ACTH or cortisone, which drugs are rapidly becoming more available to the medical profession and the public. Even in cases of osteo-arthritis, we have seen some dramatic though perhaps temporary results.

It has been our experience that with the above hospital procedures and complete bed rest continued for a two to three week period, the pain in somewhat over 75 per cent of all back cases will subside to a point where a protective support plus active physiotherapy will carry them along to a successful conclusion. The protective support usually consists of a wide belt or corset reinforced with stainless steel or aluminum stays. Occasionally, a plaster body jacket is required to give adequate support to a stubborn case which has improved but is not entirely well. It may be necessary to continue with this body jacket for some time or until all symptoms have subsided. The cast may then be bivalved and the patient started on active exercises.

All cases, no matter what form of immobilization is used, should be started on hyperextension exercises as soon as they are free of symptoms and all spasm has subsided. Other exercises are given to develop the gluteals as well as other supportive muscles of the lower part of the back.

All back cases, of course, are daily given heat and massage but no active exercises until the acute symptoms have subsided. The remainder of the cases which are not helped by any of the above-mentioned procedures may be relieved by a manipulation. This is found to be true particularly in those cases which, after four or five days of complete bed rest plus leg traction for referred pain, are not helped or even made worse. The usual technique of back manipulation is employed under anesthesia and a certain percentage of these patients are immediately relieved. In the disk cases it is possible that the ruptured nucleus is manipulated back into its lodging. We do not consider that manipulation is advisable in any case considered to be on an inflammatory basis or an actively infectious basis and that such a procedure, though it may give temporary relief, adds further irritation in the long run to the existing condition.

It is well known that at least 10 to 12 per cent of patients with low back pain due to determined pathologic conditions must undergo surgery in an effort to obtain relief from symptoms, but as this does not fall within the scope of this paper, I will summarize by saying that there are many accepted forms of conservative therapy which may work well in the hands of the individual who is accustomed to their use. It is only by careful analysis of each case and perhaps a period of study and observation that one can determine how drastic the conservative treatment must be and whether the case is one that will respond to rest of the involved muscles and joints or whether active exercises with or without support will be indicated. Frequently, only a period of study, which might perhaps include a spinal myelogram, will determine whether any form of conservative therapy is advisable.

The incidence of leukemia—an invariably fatal process at present—is increasing (see page 1172).

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

GRADUATE EDUCATION

In a recent *Atlantic Monthly* article, a surgeon and teacher in one of the medical schools evaluates thirty general practitioners that he has known for ten years. He states that, of the thirty, only five practice good medicine. The remainder make no real attempt at diagnosis, but treat symptoms. This is a rut into which a physician may fall if he forgets his education and becomes unwilling or unable to spend time and effort in making a correct diagnosis.

Almost every specialist has had the experience of seeing patients who have been in the hands of three or four practitioners before a correct diagnosis was made. Not only is it a waste of time and money to the patient but it may have tragic consequences, as when a carcinoma of the lung becomes inoperable due to the delay.

Today there is no excuse for any physician to be only a symptom-treater, because he has available to him literally hundreds of graduate courses. We are particularly fortunate in Pennsylvania because of the Graduate Education Institute sponsored by the MSSP, which is designed specifically for the general practitioner.

In Allegheny County, a physician may have his choice of many sources of graduate educa-

tion. The monthly county society meetings are actually a graduate course that goes on year after year. The Medical School of the University of Pittsburgh offers short courses every year in various subjects. At every hospital staff meeting listed in the *Bulletin* may be found up-to-date methods and ideas.

Away from home are the hundreds of courses offered by the great teaching centers, ranging in length from a few days to several months. At one of these sessions, the writer met a Virginia physician who takes two such courses a year—a week in the spring and a week in the fall. He is a general practitioner, and in his years of study has ranged the field from neurology to dermatology and back again. He is not interested in passing any boards, as he likes general practice and wants only to practice good medicine. As a result of his effort, he not only makes fewer mistakes but recognizes when a problem is too much for him and gets the patient into the care of a competent specialist in time to do the patient some good. His patients know and appreciate this, as the size of his practice tells.

With intelligent planning, each of us may design his own graduate courses for the coming winter. The systematic use of a few hours a

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

week will allow you to survey the newest material in any field and pay large dividends to your patients in the better practice of medicine. Don't be a symptom-treater. Take advantage of your opportunities!—Editorial, *Pittsburgh Medical Bulletin*, Sept. 30, 1950.

BYSTANDERS ARE NOT INNOCENT

President Eda S. Herold of the Woman's Auxiliary to the American Medical Association, in a brief article in this issue, page 1215, states: "If in the November election a wife of a physician stood apart and did not encourage people to register and vote, she would be partly at fault if the desired results were not obtained. Someone has said that the reward of a thing well done is to have done it."

"The international situation should arouse all of us to action and should eliminate all bystanders. Every doctor's wife should actively participate in all phases of the civilian defense program. Let the people of your state know that you are ready and eager to be a part of any program that will protect the health and welfare of the public."

A RECORD MEDICAL SCHOOL ENROLLMENT

From the annual report of the Council of Medical Education and Hospitals of the AMA (*Journal AMA*, September 9), we glean some interesting items indicative of a consistently considerable increase in the number of medical graduates throughout the nation:

"On the basis of enrollments in the senior class for 1950-51, the medical schools of the United States have estimated that they will have slightly more than 6000 graduates during the coming year—447 more than in 1949-50.

"The freshman class for the first time exceeded 7000 students during 1949-50. The actual number is 7042.

"On the basis of the record of the past year, the new schools that are being organized, and the expansion of existing schools that is under way, it now seems likely that within the next few years the freshman class will number close to 7500 students.

"Women totaled 1806, or 7.2 per cent, of the medical students in this country.

"The percentage of veterans enrolled in the medical schools and schools of basic medical sciences in the United States during 1949-50 was 65.9.

"Polls taken in 19 medical schools during the past year reveal that the percentage of students planning to enter general practice has increased from 36 to 47 per cent in the last three years. The number planning to specialize has decreased from 36 to 31 per cent."

EDUCATION ON ALCOHOLISM

Four Million American "Problem Drinkers"

The study club on the subject of alcoholism during the 1950 convention of our state medical society in Philadelphia, last month, constituted an objective effort, i.e., education to meet the growing problem of alcoholism. Whosoever of our readers disagrees with the premise that physicians should lead in this proposed field of education in the United States where 65 million persons "drink" is urged to read and reread the appended editorial from the *New England Journal of Medicine* for Sept. 14, 1950. Please note its brief but cogent sweep of the factors involved in the causes and the treatment of this peculiar and insidious disease.

Education on Alcoholism

There is no particular need for calling attention again to the growing problem of alcoholism, except that so important a question needs constant attention if it is to be met squarely and combated resourcefully. As one of the impedimenta of progress it is world-wide, although of special importance in the great industrial countries of the temperate zone.

It is not necessary here to go into detailed statistics; in this country are an estimated 65,000,000 persons who "drink," of whom 4,000,000 are problem drinkers. It is these with whom society is concerned, for alcohol interferes with their satisfactory adjustment to their social and economic life to the degree that, in the latter relation, a \$432,000,000 wage loss is sustained annually.

The importance of the problem is enhanced by the fact that the majority of these drinkers can be salvaged. They are not the ultimate derelicts of alcoholism; most of them are employed or are employable; they still have families that are dependent on them; many of them possess exceptional and useful skills.

No one knows better than the physician, who is the confidant of the ill, the futility of prohibition, the fruitlessness of militant temperance movements, or the brutality of treating the alcoholic patient as a criminal. No

one knows better than the medical profession that the most important factor in dealing with the public health problem of alcoholism—as with most social problems—is understanding.

To this end there must be a universal awareness of the factors involved and of the peculiar nature of the disease—its importance, its causes, its insidious character, and its treatment. Condemnation of the alcoholic must give way to charity in his misfortune, faith in his rehabilitation, and hope for his future.

MINERALS IN NUTRITION AND METABOLISM

(EDITOR'S NOTE: This is the seventh of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania.)

Studies in mineral metabolism in recent years have received added stimulus from the discovery of cobalt in vitamin B₁₂. In general, the mineral elements may function in the body in the following three ways:

1. They are the essential elements of organic compounds (e.g., cobalt in vitamin B₁₂, iron in hemoglobin, and iodine in thyroglobulin).

2. They provide electrolytes in tissue fluids (e.g., sodium and potassium).

3. They are constituents of bones and tissues (e.g., calcium and phosphorus).

Except for iodine, iron, and calcium the human body rarely lacks minerals, which are adequately supplied even in very poor diets.

The role of minerals in maintaining the acid-base equilibrium of body fluids, in providing most effectively for the osmotic pressure exerted by the blood, and in supplying a structural basis for teeth and skeletal tissue is well known. More stress is placed daily on the importance of minerals such as iron, iodine, copper, manganese, and zinc in tissue metabolism. These minerals participate in biochemical reactions as the essential parts of hormones, enzymes, and vitamins.

Iodine is essential for the synthesis by the thyroid gland of thyroxin and thyroglobulin. A deficiency of iodine, which can be overcome by the use of iodized salt, would result in a deficiency of thyroxin, an iodo-amino acid, and thyroglobulin, an iodoprotein, which regulates energy metabolism.

Iron is a component part of the protein-porphyrin pigment hemoglobin, the important oxygen-carrying agent and protein buffer of erythrocytes. Other porphyrin pigments which contain iron are cytochrome C, a hydrogen carrier,

cytochrome oxidase, the enzyme which accelerates the oxidation of cytochrome C, catalase and peroxidase, enzymes which catalyze the physiologic disposal of hydrogen peroxide. The cytochrome system is of utmost importance in biologic oxidation-reduction systems, participating in the final steps in the transfer of hydrogen to oxygen from a biologic metabolite.

A deficiency of iron, observed in anemias, results in a deficiency of hemoglobin and the iron-containing enzymes with resultant altered respiration and tissue metabolism.

Copper, although present in minute amounts, is essential as a catalyst for the synthesis of hemoglobin. A deficiency of copper results in hypochromic anemia which responds to iron therapy only in the presence of copper. It is also interesting to note that in a pure copper deficiency cytochrome oxidase activity of bone marrow is low, whereas in iron-deficient animals, with adequate copper, cytochrome oxidase activity is increased. Consequently copper, like iron, is important in the maintenance of respiratory and metabolic activity.

Manganese, zinc, and cobalt are important nutrients associated with proteins and organic molecules. Although the exact functions of manganese and zinc are not known, these ions have been observed many times either as activators or as part of the molecular structure of arginase,

ANSWER CURRENT QUESTIONNAIRES PROMPTLY

Officers and committee members of your state medical society regret the necessity for sending questionnaires to every doctor of medicine in Pennsylvania, society and non-society members alike. Each may receive more than one questionnaire before the end of 1950. They are essential to the physical welfare of civilians and soldiers, all of whom may be suddenly exposed to injury or death during war-related emergencies.

Each physician may be needed; therefore, his whereabouts, his experience and availability must be known to those who plan in advance to meet disaster, wherever or in whatever form it may occur.

Please complete and return questionnaires promptly.

which is involved in urea synthesis. Manganese is an activator for phosphoglucomutase, phosphatase, dipeptidase, and carboxylase, enzymes concerned with carbohydrate metabolism, phosphate utilization, protein metabolism, and carbon dioxide utilization, respectively.

Carbonic anhydrase, the enzyme which regulates the solution of carbon dioxide in water inside the erythrocyte, is a zinc-protein complex. Zinc has been observed as an activator for enolase and dipeptidase, enzymes involved in carbohydrate and protein metabolism, respectively. Zinc is also present in the protein hormone, insulin, which helps regulate carbohydrate metabolism.

Cobalt has been found to be part of the vitamin B₁₂ molecule. Roles other than its anti-pernicious anemia activity have not as yet been assigned to vitamin B₁₂. Cobalt is also found to activate the enzymes, arginase, phosphatase, and phosphoglucomutase.

This brief discussion illustrates the association of minerals with proteins as hormones and enzymes and other organic molecules as vitamins in the regulation of tissue metabolism. A lack of these minerals results in deficient synthesis of these biologically important compounds with altered tissue metabolism.

CARL ALPER, PH.D.

CHRISTMAS SEALS

Help Fight TB



Buy Christmas Seals

The war against tuberculosis has been one of the most successful campaigns in the drive to raise health standards in the United States. The killer is cornered, but tuberculosis has not been conquered.

The disease kills about 3000 Pennsylvanians a year. An estimated 50,000 persons in the State harbor the active germ in their bodies, although at least half of them are not aware of it.

The tubercle bacillus is a dangerous and resourceful enemy. Its defenses include an outer capsule of waxy material which many drugs cannot penetrate. It may lie dormant for long periods, surrounded by a wall of scar tissue that seals it off from the rest of the body. But if a person's natural resistance falls—because of fatigue, poor food, or extended illness—the bacillus can flare up again after years of inactivity.

Closing in on tuberculosis will require new knowledge about the fundamental processes of infection. The National Tuberculosis Association has long been a leading supporter of biologic and medical research on the metabolism of the tubercle bacillus and the defenses of the body. It has aided large-scale clinical trials of streptomycin.

This drug is not a substitute for rest or established medical procedures, but it has found its place as a valuable aid in treating certain forms of the disease—at certain stages of infection. Other substances, like PAS (para-aminosalicylic acid), are under study. In most instances today where streptomycin is indicated, it is used in combination with PAS. But we do not yet understand the complete action of these drugs, or the reason why they work in some cases and not in others.

Progress depends to a large measure on studies of

the tubercle bacillus itself. One interesting observation is that, when grown in agar cultures, harmless strains clump into spherical colonies, while virulent races tend to spread out in a thin film which has a characteristic "serpentine" pattern. But this difference is only an indication of underlying differences which cannot be seen with the naked eye and yet must be analyzed before new weapons are found against tuberculosis.

Significant differences have been found at a deeper level, which involve work on the biochemistry of tuberculosis. Harmful bacilli—but not the innocuous varieties—combine readily with the molecules of neutral red and certain other dyes, a promising lead for work on their distinctive chemical structure. Furthermore, some of the substances that prevent the organisms from joining with the dyes also prevent them from immobilizing white blood cells. Since similar substances are present in normal tissues, this finding may provide new insight into the mechanisms of resistance to infection.

These are a few examples of investigations under way as part of the broad campaign to control tuberculosis. The program includes, in addition to medical research, the promotion of x-ray surveys to find early tuberculosis, the promotion of diagnostic and treatment facilities, rehabilitation services for patients, and widespread public education.

These are but a few of the activities of the state and local associations affiliated with the National Tuberculosis Association in a year-round campaign against the disease supported by the annual Christmas Seal Sale. The citizen program in Pennsylvania is conducted by the Pennsylvania Tuberculosis and Health Society and its affiliated organizations in cooperation with the medical professions and the official health agencies. The problems which come with new knowledge call for increased support of basic laboratory research, the spearhead in the attack on tuberculosis.

WILL YOU COOPERATE?

Important Questionnaire Soon to Be Mailed to All Pennsylvania Physicians

ON THE following two pages there is reproduced a questionnaire which will be mailed early in December to every physician registered by the State Board of Medical Education and Licensure. This questionnaire has been prepared by the Committee on Procurement and Assignment and the Committee on Emergency Disaster Medical Service of The Medical Society of the State of Pennsylvania. The answers to the questions will be recorded on a statistical card so that, in case of a national emergency, immediate and accurate data on each doctor within the State may be available to the officers of the Society.

The form will be sent to you in duplicate with a piece of carbon paper already inserted. Both copies are to be returned to the State Society's office at 230 State Street, Harrisburg, just as soon as it is possible to do so. It is hoped that each physician will return his form within forty-eight hours after receipt.

While it is anticipated, in view of the present international situation, that the two committees which have prepared this form will probably be called upon to use the information before other committees of the Society will have need for it, there is nothing contained in this form that obligates anyone either to military service or civilian defense duty.

Invaluable statistics will be uncovered in the answers received. For example, at the present time there are no accurate figures available on the number of physicians in the various specialties, those on hospital staffs, or those who have had previous military experience.

Please remember that this is a forward-looking State Society project, and the success of it depends upon the promptness with which each member of the Society returns his completed form.

We have expended considerable money and effort in convincing Congress and the public that medicine can take care of its own problems. If we are not prepared to meet any emergency in such a way that neither the public nor the armed services will suffer unduly, this expenditure will have been in vain. Will you cooperate?

IF PEN OR PENCIL IS USED TO COMPLETE QUESTIONNAIRE, PLEASE PLACE
FORM ON HARD WRITING SURFACE TO INSURE CARBON LEGIBILITY

CONFIDENTIAL

COMMITTEE ON PROCUREMENT AND ASSIGNMENT
In Cooperation With
COMMITTEE ON EMERGENCY DISASTER MEDICAL SERVICE

The Medical Society of the State of Pennsylvania
230 State Street, Harrisburg, Pennsylvania

Instructions: Please use the typewriter or print answers. Disregard all marginal figures.
These are for use on key punch cards only. Indicate answers in squares, thusly ☒ X

IMPORTANT For processing these questionnaires, it is absolutely imperative that the number of your medical license, issued by the Pennsylvania Board of Medical Education and Licensure be included in the space provided below.

(1-5) Number of your Pennsylvania Medical License as shown on address label, not your renewal number which appears on your pocketbook card _____

(6-22) Name _____ (23-24) County _____ City _____
6 Given Name 7 Middle Name 8-22 Surname

Street Address _____ Telephone number at which you may be reached: _____
Home Office

7 a.m. to 7 p.m. 7 p.m. to 7 a.m. (25) Race White ☐ Negro ☐ Other ☐ (26) Sex Male ☐ Female ☐ (27-28) Year of Birth _____

(29) Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ 30-31 Number of Dependents Under 18 years of age _____ over 18 years of age _____

(32) Citizenship: Native Born ☐ Naturalized ☐ Non-citizen ☐ (33) Graduate of: University of Pennsylvania School of Medicine ☐ Jefferson Medical College ☐

Hahnemann Medical College ☐ Women's Medical College ☐ University of Pittsburgh School of Medicine ☐ Temple University School of Medicine ☐

Other _____ (34-35) Year of Graduation _____ (36-37) Year licensed in Pennsylvania _____ Are you now a member

of a county medical society? Yes ☐ No ☐ (38-39) If answer is "yes", which county society? _____ (40) Check one: Active Member ☐

Associate Member ☐ Affiliate Member ☐ Are you a member of any hospital staff? Yes ☐ No ☐ Name of principal hospital _____

(41) Do you hold any of the following appointments requiring full time? State Health Department ☐ Teaching ☐ Research ☐ Hospital Administration ☐

Executive ☐ Industrial ☐ Veteran's Administration ☐ Other _____ If yes, give title or

affiliation _____ (42) Type of Practice: (Indicate only one of the following) General ☐ Special ☐ Divided ☐

Indicate the areas from which you draw the greatest percentage of your practice _____

Indicate percentage of practice devoted to specialty 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0% ☐ (43) Are you certified by a special examining board? Yes ☐ No ☐

(44-51) If any portion of your practice is devoted to a specialty or specialties, indicate which of the following is your primary specialty by placing a (1) in the block provided. Indicate your sub-specialty by placing a (2) in the block provided. Indicate in the second block the number of years you have practiced this specialty.

General Practice	1	☐	yfs	Obstetrics and Gynecology	8	☐	yfs	Plastic Surgery	15	☐	yfs
Pediatrics	2	☐	yfs	Internal Medicine	9	☐	yfs	Neurological Surgery	16	☐	yfs
Psychiatry and Neurology	3	☐	yfs	Pathology	10	☐	yfs	Physical Medicine and Rehabilitation	17	☐	yfs
Orthopedic Surgery	4	☐	yfs	Ophthalmology	11	☐	yfs	Preventive Medicine and Public Health	18	☐	yfs
Dermatology and Syphilology	5	☐	yfs	Otolaryngology	12	☐	yfs	Proctology	19	☐	yfs
Radiology	6	☐	yfs	Surgery	13	☐	yfs	Thoracic Surgery	20	☐	yfs
Urology	7	☐	yfs	Anaesthesiology	14	☐	yfs	Industrial Medicine	21	☐	yfs
								Any other specialty	22	☐	yfs

List special postgraduate work taken since graduation from medical school: _____

(52) Method of Practice Individual ☐ Partnership ☐ Group ☐ Industrial ☐ Governmental Service ☐ Resident ☐ Retired ☐

Now in military service ☐ Not in practice ☐ Other _____ 10

(53) Have you had previous military service as a medical officer? Yes ☐ No ☐

World War I ☐ Since World War II ☐ World War II and Since World War II ☐

World War II ☐ World Wars I and II ☐ World Wars I and II and Since World War II ☐

(54) Indicate branch of service Army ☐ Navy ☐ Air Force ☐ U.S.P.H.S. ☐

(55-58) Total number of months active military duty Domestic _____ Overseas _____

(59) Highest rank held during service:

2nd Lt. or Ensign ☐ Captain or Lt. ☐ Lt. Col. or Comdr. ☐ Brig. General or Commodore ☐

1st Lt. or J. G. ☐ Major or Lt. Comdr. ☐ Colonel or Captain ☐ Major General or Rear Admiral ☐

(60) Present commission held None ☐ Army ☐ Navy ☐ Army Reserve ☐ Naval Reserve ☐ Air Force ☐ Air Force Reserve ☐

National Guard ☐ U.S.P.H.S. ☐ U.S.P.H.S. Reserve ☐

(61) Rank of present commission:

2nd Lt. or Ensign ☐ Captain or Lt. ☐ Lt. Col. or Comdr. ☐ Brig. General or Commodore ☐

1st Lt. or J. G. ☐ Major or Lt. Comdr. ☐ Colonel or Captain ☐ Major General or Rear Admiral ☐

(62-64) If number is known, indicate primary military occupational specialty (Army MOS—Navy SN) _____. If number is unknown, write name of specialty to which you are presently assigned or were assigned during military duty _____

(65-66) Type of military and civilian service which you consider yourself best qualified to perform: _____

(67) If not attached to any service, indicate the services to which you would prefer to be assigned in the event of total mobilization. Army ☐ Navy ☐

Air Force ☐ USPHS ☐ National Guard ☐ State Guard (Duty within state) ☐ Volunteer Health Work ☐ Local Defense Work ☐ None ☐

If you are not selected for any of the above, will you cooperate with your county medical society in caring for the civilian medical needs of your own and neighboring communities under such regulations as your county and state medical society may adopt? Yes ☐ No ☐

(68) Do you now claim that you have any physical defect that would make you unfit for military service? Yes ☐ No ☐ If physically unfit, indicate reason for disability: _____

(69-70) Did you have any portion of your education paid for by the U. S. Government in the ASTP or V12 programs? Yes ☐ No ☐ If yes, indicate number at months _____. Also indicate name of school attended _____. Also indicate any other special training which you may have had at government expense, not including veterans' benefits: _____

(71) Indicate the language in which you are most proficient.

Russian ☐ Greek ☐ French ☐ Chinese ☐ German ☐ Spanish ☐ Persian ☐ Italian ☐ Swedish ☐ Other _____ 10

Signature _____

(72-74) THE STANDARD REGISTER CO., INC., DAYTON, OHIO ZIP 45221

Date _____

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Course Available

During the present school year, the University of Pennsylvania will conduct two courses in the diagnosis and treatment of cancer.

The Cancer Control Division of the Pennsylvania Department of Health will pay the tuition of each registrant and will provide \$200 for living expenses.

Each course will be two weeks long and will consist of lectures, panel discussions, and clinical demonstrations. Four evening lectures will be given by outstanding authorities in the field of cancer in various parts of the country.

The dates for the courses are: January 22 to February 3, 1951; and April 9 to 21, 1951. Each class is limited to 15 and application blanks may be secured by writing to the secretary of the Cancer Commission of the University of Pennsylvania, Hospital of the University, 3400 Spruce Street, Philadelphia.

"CA"

Dr. Charles S. Cameron, medical and scientific director of the American Cancer Society, is the editor of the society's new publication for doctors, "CA."

"CA" is a bulletin of cancer progress designed to present regularly to the practicing physician a survey of clinical and research progress in the field of cancer, and to do it in a form which the busy general practitioner can use. It is edited with the problems of the general practitioner in mind because he appears to occupy the key position in the cancer control team today. He sees the patient first, and his role in determining *when* the patient is treated is usually of greater importance than that of the specialist who will decide *how*.

"CA" appears bimonthly on the first of the month and is sent by the Pennsylvania Division, American Cancer Society, to members of The Medical Society of the State of Pennsylvania. Subscription and mailing costs are paid by funds

allocated to the Pennsylvania Division by its county units.

Each issue will contain one or more features by outstanding authorities in a special area of cancer, a section devoted to the questions most frequently asked about cancer by doctors, a clinicopathologic conference or cancer clinic as recorded on the spot in various teaching institutions throughout the country, and a department devoted to news of the advancing cancer front as announced by responsible scientific investigators, and, when of interest, the version of the truth as presented in the popular press.

New Film

The Commission on Cancer of The Medical Society of the State of Pennsylvania has approved, with reservations, the film "Breast Self-Examination," a 15-minute color motion picture aimed at reducing breast cancer deaths by teaching women how to examine themselves.

Before the film can be shown to lay audiences, these provisions should be met:

1. The film screened and approved by the county medical society where it is to be shown.
2. A statement prepared by Dr. S. Gordon Castigliano, chairman of the Commission on Cancer, read to the audience viewing the film.

"Breast Self-Examination" was produced by the American Cancer Society and the National Cancer Institute of the United States Public Health Service. It teaches a four-step technique which can reveal breast lumps as small as half an inch in diameter.

A review in the *Journal of the American Medical Association* called the film "excellent for physicians and laymen alike, since its influence should make first the house and then the physician's office a 'cancer detection center' for lesions of the breast."

It is available on a loan basis through the county units of the Pennsylvania Division, American Cancer Society.



OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D.,

Secretary-Treasurer



Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

AMA CLINICAL SESSION

The clinical session of the American Medical Association will be held in Cleveland, Ohio, Dec. 5 to 8, 1950.

The clinical sessions are designed to help today's general practitioner get the latest information regarding medical developments and to keep him right in step with specialists in a variety of fields.

This year's meeting will be held in the Cleveland Public Auditorium and will deal with new treatment of medical problems ranging from the common cold to mental illnesses. Its technical exhibits will feature information on drugs, equipment, books, and other products. Its scientific exhibit will offer special demonstrations on fractures, diabetes, rheumatism, and arthritis.

Doctors will hear leading medical authorities discuss treatment of actual cases of cancer. And, through the newest medium of color television, family doctors will actually see a program of surgery, clinical treatment, and examination direct from University Hospital in Cleveland. The telecasts, sponsored by Smith, Kline & French Laboratories of Philadelphia, are earmarked as one of the highlights of the meeting.

Another of the outstanding events of the December clinical session will be the election of America's typical family doctor to receive one of American medicine's highest honors, the General Practitioner's Award. Doctors in line for this recognition are nominated annually by local and state medical societies and elected by the AMA House of Delegates. The award goes to the doctor who best exemplifies the medical profession's standards of service to patient, community, and country.

Last year's clinical session in Washington, D. C., drew more than 4000 family doctors from every part of the United States. This year the

AMA has issued a blanket invitation to all members of the Canadian Medical Society, and an even larger attendance is anticipated at the Cleveland meeting.

ANOTHER CENTENARIAN

Amid the flash of news photographers' cameras on August 21, Mrs. Mary Dunkelberger, Shillington, Pa., was presented with the Society's centenarian plaque in observance of her one hundredth birthday. The presentation was made by President E. Roger Samuel. It was one of 27 similar presentations made during 1950 throughout the Commonwealth.

In making this presentation, it was necessary for the Berks County Medical Society to call on the Northumberland County Medical Society for its cooperation. It so happens that Mrs. Dunkelberger, who makes her home in Shillington (Berks County), experienced the misfortune of falling and breaking her hip while visiting her grandson in Northumberland County. She was hospitalized in the Sunbury Hospital and was released just a few days prior to her one hundredth birthday and taken to the home of her grandson, Mr. Bruce Roper, Northumberland, R.D. 1, where the presentation was made.

This was more than just "good public relations," although it was that. It symbolized the good will of the Medical Society. It paid tribute to Mrs. Dunkelberger for 100 years of healthful living, and the tribute was sincere.

Dr. Samuel was assisted in making this presentation by Dr. J. Robert Vastine, of Shamokin, president of the Northumberland County Medical Society, and Dr. Mark K. Gass, secretary of the county society. Later the three doctors gave Mrs. Dunkelberger a brief medical ex-



Dr. Mark K. Gass, left, and Dr. J. Robert Vastine, right, look on as Dr. E. Roger Samuel presents the Society's centenarian award to Mrs. Mary Dunkelberger, age 100. The event took place on August 21 at the home of Mrs. Dunkelberger's grandson in Hilbish Heights, Northumberland County.

animation, each marveling at the good health of the aged woman.

Since the idea was inaugurated in 1948, one hundred and twenty-three centenarian awards have been presented by the county societies to Pennsylvania residents who have attained their one hundredth year. This is a project of the Committee on Public Relations of The Medical Society of the State of Pennsylvania.

COMMITTEE ON PESTICIDES

A Committee on Pesticides of the Council on Pharmacy and Chemistry of the American Medical Association has recently been established at the headquarters of the American Medical Association to study the health problems associated with the use of pesticides (insecticides, rodenticides, fungicides, herbicides, and similar types of economic poisons). As part of its study on the safety and effectiveness of these chemicals, the committee is undertaking an intensive educa-

Tonight—as you and I dedicate ourselves to another year of wholehearted effort to the care of the sick, to the advancement of the span of human life, and to the preservation of our right to practice free medicine in a free country—may we justify as our earned reward the faith and confidence of all the people of our country. Read the President's address (10 minutes) on page 1161.

tional program to assist physicians and other health practitioners in recognizing and overcoming the difficulties which certain of the newer compounds present.

The first of a series of committee reports on the medical aspects of pesticides has been published in the *Journal of the American Medical Association*. Reprints of this report, entitled "The Pharmacology and Toxicology of Certain Organic Phosphorus Insecticides," and future committee reports will be available through our Society's package-by-mail library loan service.

OUTLINE OF PUBLIC LAW NO. 779

Providing for Special Registration, Classification, and Induction of Certain Medical, Dental, and Allied Specialist Categories of Persons

Amends the Selective Service Act by adding the following provisions:

Authorizes the President to require special registration of and, on the basis of requisitions submitted by the Department of Defense and approved by him, to make special calls for male persons qualified in needed medical, dental, and specialist categories who have not reached the age of 50 at the time of registration.

Provides that persons called shall be liable for induction for not to exceed 21 months of service. Further, that reserves will not be liable for registration or induction since they are already subject to direct call from their component military service.

In registering and inducing persons covered by this public law, the President is authorized to register and induce in the following order of priority:

- (1) Former ASTP and V-12 students and such persons who were deferred during World War II for the purpose of pursuing a course of instruction in one of these covered categories, who have had less than 90 days of active duty in the armed forces or the Public Health Service, exclusive of the time spent in postgraduate training.
- (2) The same group as covered in the first category who have had 90 days or more but less than 21 months of active duty in the military or Public Health Services, exclusive of the time spent in postgraduate training.
- (3) Those who did not have active service in the military or Public Health Services subsequent to Sept. 16, 1940.
- (4) Those not included in the first and second priorities who have had active service in the military or Public Health Services subsequent to Sept. 16, 1940. Inductions of persons in this fourth priority group shall be made in accordance with regulations providing that those who have had the least amount of service shall be called ahead of those with more service.

Provides for deferment of covered registrants whose deferment is found to be equitable and in the national

interest, taking into consideration length of previous service, extent of participation in the ASTP or V-12 programs, reasons of hardship or dependency, and the maintenance of the national health, safety, or interest.

Expresses the wish of Congress that the President shall provide for the annual deferment from training and service of premedical, predental, pre-optometry, pre-osteopathy, and preveterinary students at least equal to the number of such students in attendance at colleges and universities in the United States at the present levels.

Provides that a National Advisory Committee be established to advise the Selective Service System and to coordinate the work of state and local voluntary and advisory committees as may be established to cooperate with the National Advisory Committee with respect to needed medical, dental, and allied specialist categories of persons. The members of the Advisory Committee are to be selected from among individuals outstanding in medicine, dentistry, and the allied sciences. It is mandatory that representatives from medicine and dentistry be represented on the committee. This committee would consider both the respective needs of the military forces and of the civilian population. The committee is intended to parallel the Procurement and Assignment program of World War II.

Provides that any *reserve* officer called to active duty with or without his consent shall be entitled to the \$100 per month pay bonus (but not inductees).

Secretary of Defense is authorized to transfer officers between the armed services with the consent of the officer and the services involved.

Protects such officers who are transferred among the services in respect to promotion, rank, seniority, leave, and retirement.

Gives the President authority to issue regulations making it possible for officers who served as physicians or dentists in the armed forces or the Public Health Service subsequent to Sept. 16, 1940, to be promoted to such grade or rank as may be commensurate with their education, experience, and ability at the time they are recalled to active duty.

Provides that *persons drafted* shall not be entitled to the \$100 per month pay bonus.

States that "allied specialist categories" shall include but not be limited to veterinarians, optometrists, pharmacists, and osteopaths.

Calls for the termination of this Act concurrent with the Selective Service law on July 9, 1951.—From Bulletin No. 65, Sept. 15, 1950, by JOSEPH S. LAWRENCE, M.D., Washington Office of AMA.

BLOOD PROCUREMENT *

"On July 11 and 12, 1950, at a meeting in Boston of the Committee on Blood and Blood Derivatives of the American National Red Cross, together with its Medical Advisory Committee on the National Blood Program, there were present, by invitation, representatives of the American Medical Association, the American Hospital Association, and the American Association

* Excerpted from an editorial reprinted from the *Journal of the American Medical Association*, 144, 7: 550-551, Oct. 14, 1950.

tion of Blood Banks. The agreement drawn up at this meeting sets forth the relation among these four organizations in peacetime and in the event of a national emergency.

"The Committee on Blood Banks heartily approves the agreement reached in Boston and has been notified of approval by the Board of Trustees. The committee recognizes that the *modus operandi* of this agreement will necessitate many adjustments to meet local conditions. From time to time the committee will report to the Board of Trustees plans for implementation of this agreement with the recommendation that they be published.

"At an early date the American National Red Cross will request the cooperation of a number of cities in the procurement of blood. When a community is thus selected, the professional groups interested will be invited to work out a program of procurement most suitable for that particular community. This group will include the local Red Cross chapter, the county medical society, local hospitals, local blood banks, if any, and probably the local public health officer."

A.C.S. TO CONTINUE STANDARDIZATION PROGRAM

WALTER F. DONALDSON, M.D., Secretary,
Medical Society of the State of Pennsylvania.

The following release, dated Oct. 21, 1950, from the American College of Surgeons, is transmitted for your information:

At their meeting today in the Hotel Statler, the Regents of the American College of Surgeons voted unanimously to continue the Hospital Standardization Program of the College.

A spokesman for the Regents stated that this action does not necessarily preclude consideration of proposals for the participation of other interested agencies in this program, but does make it clear that the American College of Surgeons has an undiminished interest in it and will consider no proposal which will not insure its continuation in the best interests of the public.

(Signed) ERNEST B. HOWARD, M.D.,
Assistant Secretary,
American Medical Association

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Adams County	\$25.00
Woman's Auxiliary, Bucks County, memory of	
Dr. J. E. Barsby	5.00
Woman's Auxiliary, Juniata County	5.00

Total contributions since 1950 report . . . \$35.00

MEDICINE PREPARES FOR ATOMIC DISASTER

FREDERIC B. DAVIES, M.D.

Scranton, Pa.

One plane—one bomb—100,000 casualties!

This, in a few words, summarizes a condition which, created in a few seconds by atomic warfare, may confront our metropolitan areas in days to come.

What has your community done to conform with the national and state-wide civil defense program? Where does the medical profession fit into this picture? When do they start? What should they do? Your Medical Disaster Committee, whose members have been studying this problem during the past year, submits the following suggestions:

Immediate activation of all civil defense groups at the county level is imperative. Do not expect too much supervision or many suggestions from the national organization and the National Security Resources Board (NSRB). The state organization has outlined a program in conformation with the Hopley Report recently submitted to NSRB. At present this differs but little from the setup of civil defense practices during the later months of World War II.

By order of Governor Duff in letters issued May, 1950, "we are now going ahead with a necessary and accelerated program of county and municipality civil defense organization based upon a primary county role of coordination and support and municipal role of operation and cooperation. The county organization provides for the president judge of common pleas court within the county, in every county which has a judge, to serve as the County Defense Coordinator and as head of the County Defense Council and of the Council Steering Committee. In the counties where there is no local judge, or in any emergency eliminating the one presiding, the next ranking judges, followed by the county superintendent of schools, are designated in that order of succession.

"The Deputy County Defense Coordinator will be selected from either the civilian population or official lists. The selection will be based entirely upon capacity for efficient voluntary service in the vital public interest during a critical period, and necessarily involving considerable sacrifice of time and executive function of high order, and perhaps with hazard."

(NOTE: The Deputy County Defense Coordinator is the "spark-plug" of the organization and preferably should have had military and/or civil defense experience during World War II.)

"The County Defense Steering Board will comprise the coordinator and deputy coordinator, representatives of the state guard and state police, the six chiefs of the sections of the County Defense Council, and six especially qualified civilians now not holding any selective or appointive remunerative public office to be appointed by the County Defense Coordinator."

"The six chiefs of sections of the County Defense

Council comprise the county superintendent of schools, county sheriff, president of board of county commissioners, representative of the telephone company in the locality, district attorney, and an *especially capable medical doctor to be appointed by the County Defense Coordinator following conference with the county medical society.*"

Although this formidable table of organization places medical organization at the foot of the list, it is the keystone of the whole civil defense program. The medical aspects of atomic defense are so tremendous and far-reaching that immediate and concerted action is imperative. Before consideration of the primary missions of medical care, service of supply and evacuation incidental to actual atomic disaster, we must deal more realistically with the possibilities of prevention of injury and loss of life.

It is generally believed that from 20 to 50 per cent of lives lost from atomic disaster might be saved if education of the public and large numbers of civilian and military personnel for special jobs in atomic warfare is provided. Knowledge creates a proper respect for the special hazards of atomic warfare, a psychologic preparedness, and avoids the undesirable extremes of fear and ignorance.

Large-scale training must be provided for such specialists as first-aid personnel, fire fighters, auxiliary police, evacuation control personnel, and decontamination groups. Stock piles of food supplies, medical supplies, and disaster equipment will be required in relatively invulnerable and widely separated locations. Preparations will be required for mutual aid between cities and major installations.

But where does the medical profession start? When do they start? What should they do?

1. The Medical Service and Evacuation Division should have been set up immediately upon appointment of the County Defense Coordinator months ago. Key men for each branch of medical service, as outlined below, and their assistants must be appointed. These chiefs of service should meet regularly with the medical coordinator for briefing on their specific duties and for an indoctrination and orientation program covering the many phases of atomic medicine.

2. Through cooperation with the Red Cross, which should be included in the Medical Service and Evacuation Division, first-aid training centers must be set up for the thousands of civil defense workers involved in this program. Accredited teachers of the National Red Cross and the United States Bureau of Mines should be given short refresher courses in present-day methods and the needs in atomic disaster. Every certified civil defense worker must attend a series of orientation and training sessions, the first of which is the standard Red Cross course in first aid.

In atomic disaster, creation of tens of thousands of casualties is a matter of minutes or even seconds. Hospitals, hospital personnel, physicians, and nurses may be completely wiped out within a radius of three to five miles of the detonation center. Immediate first aid and evacuation is essential, hence the need for training all civil defense workers and millions of the civilian population in first aid.

EDITOR'S NOTE: Published with the approval of the chairman and the co-chairman (Drs. Theodore R. Fetter and Charles Wm. Smith) of the Committee on Emergency Disaster Medical Service of The Medical Society of the State of Pennsylvania.

In searching for an adequate and efficient method for training large numbers in first aid, a "station rotation" program has been devised, employing six qualified teachers, each of whom gives a three-hour session on two specific units of the twelve-unit standard course in first aid. Such specialization improves the quality of teaching and allows more time for individual demonstration and practice. Groups of 30 make up a class. Each group (and individual) attends six sessions (given twice weekly) and completes the course in three weeks. This method eliminates the problem of recurrent absenteeism and the "slow starter" by allowing the individual to continue until he attends his six sessions (see chart). Such courses are best given in public schools where at least six classrooms and an assembly room are available.

Mass instruction of large groups who sat through "short courses" in the World War II civil defense training program proved to be in many instances a waste of time and source of serious misconceptions. Such training methods as outlined above, utilized at ten centers and employing 60 teachers, will graduate a minimum of 1000 trained first-aiders in the first eight weeks and continue to complete the training of 300 each successive week as long as needed.

Once first-aid training is well under way, attention must be given to organization of graduate nursing facilities, implementation and expansion of nurses' aide programs, and provision of home nursing courses.

Of primary importance is the rapid expansion of blood bank facilities with particular regard to recruitment of donors in a more orderly and enlightened manner. The National Blood Grouping Campaign about to be launched will emphasize the need for blood donors. Consideration is being given to some method of permanent marking of blood group on the body. Large stocks of plasma and blood derivatives must again be built up, as well as supplies of materials for mass bleeding in case of atomic disaster.

Actual implementation of the civil defense plan is through a county control center from which emanate orders and instructions to the subsidiary control centers in boroughs, townships, and municipal divisions. The

chief of the medical division sits with the county control board at the county center.

Each subsidiary control center group is made up of the chairman of civil defense for that area, the commander of the center, the chiefs of fire wardens, auxiliary fire and police, one physician, one nurse, and a Red Cross coordinator, the latter directing co-chairmen in charge of first aid, blood banks, nurses' aides, home nursing, and disaster services (including food, shelter, emergency supplies, and transportation in cooperation with these major divisions at the county level).

The medical division of the County Defense Council comprises two major divisions: (1) public health and (2) Medical Care Services.

Public Health

(Qualified doctor of medicine in charge) Should be concerned with the control of the health of the public in general, as distinguished from administering to the needs of any one individual. Insofar as possible, the civil defense public health organization should parallel that of the customary municipal pattern, supplemented by such additional services as may become necessary due to the emergency. Public health services comprise:

Communicable Disease Control: Should be responsible for the prevention and control of communicable diseases. This involves the detection and isolation of cases of infectious diseases, the elimination of their cause, and their prevention by immunization, mass dosage measures, disinfection, and delousing.

General Sanitation: Should inspect existing and emergency sources of food and milk to determine their cleanliness and purity and, too, that they are not sources of possible disease outbreak.

Vital Statistics: Should be responsible for the keeping of records, including births and deaths, occurring during the emergency.

Mortuary Service: Should collect and identify the dead, preserve the effects and records of the dead; and prepare for disposal, and actual disposal of the bodies.

FLOW CHART FOR STATION-ROTATION PLAN IN TEACHING STANDARD RED CROSS FIRST AID

Teacher		I	II	III	IV	V	VI	No.
Red Cross Units		1 and 2	3 and 4	5 and 6	7 and 8	9 and 10	11 and 12	Grad
		Group						
Period	I	A						
Period	II	B	A					
Period	III	C	B	A				
Period	IV	D	C	B	A			
Period	V	E	D	C	B	A		
Period	VI	F	E	D	C	B	A	30
Period	VII	G	F	E	D	C	B	60
Period	VIII	H	G	F	E	D	C	90

Groups A, B, etc. = standard 30 student group.
Each period = 3 hours in one evening.
Class meets twice weekly (Tuesday to Friday)

Maternal and Child Health: Should be concerned with the special problems of obstetrics and pediatrics arising in connection with emergency conditions.

Laboratory: Should be responsible for all laboratory procedures, including the blood programs.

Industrial Medicine and Hygiene: Should be responsible for control of the special problems and conditions arising in connection with industrial health during the emergency.

Mental Hygiene: Should be responsible for the care of mental cases arising from emergency conditions.

Public Health Nursing: Should be responsible for administering the public health nursing program arising in connection with the emergency.

Nutrition: Should be concerned with the nutritional problems of the emergency diet.

Medical Care Services

Casualty Medical Service: These physicians may be needed not only in their own communities but also for duty with mobile medical casualty units which can be sent to the assistance of other stricken cities. There is a large group of physicians who have had military experience and training in the management of large numbers of casualties. These men will form a nucleus for the operation. A complete Casualty Medical Service should include consultants in the following specialties:

General surgery	Ophthalmology
Orthopedics	Otolaryngology
Thoracic surgery	Anesthesiology
Neurosurgery	Obstetrics
Plastic surgery	Radiology

Medical Practice Services: At any given time, there are many who are seriously ill, at home or in the hospitals, who must be provided with adequate medical and nursing care, drugs and medical supplies, despite the occurrence of enemy action in a community.

The Medical Practice Section should have consultants in the following specialties:

Internal medicine	Dermatology and
Neuropsychiatry	syphilology
Pediatrics	Urology
	General practice

Each consultant is responsible for the supervision of patients suffering from illness or injury in his special field.

Nursing: Graduate nurses, practical nurses, and nurses' aides should be responsible for the maintenance of nursing services, bedside and clinical and first-aid nursing.

Pharmacy: Provide pharmaceutical services in emergency medical installations as well as similar service for existing hospitals.

Dentistry: Should make up a separate unit including dental hygienists and technicians, as well as qualified dentists.

Physical Medicine: Responsible for treatment and rehabilitation of casualties.

Red Cross: Arrange an adequate long-range program for providing the standard course in first aid to all civil defense workers and thereafter to large units of the population at large; to implement the *procurement of whole blood* and plasma on a wholesale emergency basis, when needed; to provide training for hundreds of *nurses' aides* to supplement the regular and emergency hospital nursing program; to continue and enlarge upon courses in *home nursing*; through their disaster service to provide supplies, transportation, and shelter in cooperation with and under the direction of the local civil defense authority.

A further responsibility of the Medical Division is the organization of the members of hospital staffs, hospital nurses, technicians, and other hospital personnel in preparation for anticipated overwhelming numbers of casualties. Storage of and provision for necessary supplies must be considered. Emergency and evacuation hospitals must be designated for regions well away from a possible disaster area. To staff these auxiliary centers, special field hospital units should be recruited from staff members and trained in specific disaster duties.

Veterinary Service

(Qualified veterinarian in charge) Should be responsible for animal health and the inspection of all meat and dairy products intended for human consumption and, where possible, inspect the source or sources of supply.

Medical Supply

(Qualified pharmacist in charge) Large quantities of medical and surgical supplies and equipment, drugs and biologicals will be required in any attacked area. But many of these items are perishable within a short time, so that to avoid a serious and costly depletion of the nation's medical supplies, regional medical supply depots are proposed.

However, the chief of this service should have at hand definite information as to the medical supplies readily available locally. This important information may be obtained from a survey of drug stores and supply houses in the area.

Medical Evacuation Service

(Qualified person, preferably with hospital management experience, in charge) Provide in advance assembly areas and organize and train groups in medical evacuation routes, rest stops, feeding points; survey the number of ambulances in the area.

Operate in coordination with the transportation section and with the police services; maintain vehicles assigned to evacuation.

Administrative Service

(Hospital superintendent in charge) Cooperate with the other sections in making plans and training schedules; make plans and surveys for hospital facilities; mobilize medical technologists; secure other trained personnel for duty in the various sections; handle personnel records, including medical; handle other fiscal matters.

Such a plan as outlined above was placed in operation in Lackawanna County early in August, each panel and division reported as complete on September 1, and the first practice "black-out" held September 21. Complete organization of civilian units by a very energetic, hard-working World War II trained deputy coordinator, in cooperation with the Medical Division chairman (president-elect of the county medical society), the county chairman of Red Cross, and with the liaison service of the District 15 Medical Defense Coordinator, resulted in rapid organization of the Lackawanna County Civil Defense Unit on a purely voluntary, non-political, community basis. *All this was done without a penny of appropriation or a single paid employee.*

Visual aids were of immeasurable help in stimulating interest and enthusiasm. They form the first step in the psychologic warfare against fear of the incomprehensible. Dozens of county and district meetings, *never of more than one hour duration*, were planned around such sound color film presentations. At least five 20 to 30 minute films on the "Medical Aspects of Atomic Bombing" and five other correlated films are available from the Office of Civil Defense, South Office Bldg., Harrisburg.

Obviously, this plan may be expanded or contracted to fit the population and respective industries of each county. Refer to the Hopley Report to NSRB for more detailed explanation of the Medical Division setup and mission.

In conclusion, remember that the aftermath of atomic bombing—blast, tremendous heat, and immediate and remote radiation effects—creates tremendous numbers of casualties. Following airborne atomic explosion, there is little radioactivity in the air after 90 seconds. Yet everything stops—communication, transportation, power, water, sewage—and human life. Thousands suffering from serious burns, multiple lacerations from flying glass, and crushing injuries of all kinds must be sought out by mobile rescue units, given immediate treatment, and evacuated to a safe place.

Panic, hysteria, and further loss of life may be prevented by adequate far-sighted, immediate organization and education. Medical preparedness is absolutely essential. Will it be too little—and too late?

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Resignations (1), Transfers (7), Deaths (14)

ALLEGHENY: *Deaths*—Charles S. Caldwell, Pittsburgh (Hahnemann Med. Coll. '03), September 3, aged 69; Joseph L. Conrad, McKeesport (Hahnemann Med. Coll. '06), August 30, aged 70; Merle R. Hoon, Pittsburgh (Univ. Pa. '18), August 31, aged 58; Caleb McCune, McKeesport (Univ. Pa. '07), August 29, aged 70; William J. Sterrett, Beaver Falls (Univ. Pgh. '01), September 5, aged 76.

BUCKS: *Deaths*—John E. Barsby, Quakertown (Jeff. Med. Coll. '20), September 1, aged 69; William G. Moyer, Quakertown (Hahnemann Med. Coll. '05), September 8, aged 68.

DELAWARE: *Transfers*—Harry H. Pote, Philadelphia, and Robert C. Stewart, Clifton Heights, from Philadelphia County Society.

FAYETTE: *Transfer*—Harry J. Jordan, Uniontown, from Allegheny County Society.

LAWRENCE: *Transfer*—William S. Gibson, New Castle, from Greene County Society. *Deaths*—Charles F. Flannery, New Castle (Eclectic Med. Coll. '11), August 28, aged 74; Thomas M. Shaffer, New Castle (Univ. Pgh. '12), August 10, aged 69.

MERCER: *Death*—Patrick E. Biggins, Sharpsville (Med.-Chi. Coll. '07), August 25, aged 70.

MONTGOMERY: *Transfer*—Sterling A. MacKinnon, Norristown, from Philadelphia County Society.

NORTHAMPTON: *Deaths*—John Edgar Fretz, Easton (Univ. Pa. '97), August 31, aged 76; Loyal A. Shoudy, Bethlehem (Univ. Pa. '09), August 31, aged 70.

PHILADELPHIA: *Resignation*—Frances M. Sher Sharpe, Philadelphia. *Transfers*—Daniel Edw. Boyle, Skillman, N. J., to Somerset County (N. J.) Medical Society; Pasquale Gallizzi, Hartford, Conn. (formerly of Philadelphia) to Hartford County (Conn.) Medical Society. *Deaths*—Thomas O. Nock, Philadelphia (Univ. Pa. '86), August 31, aged 87; DeSiderio Roman, Philadelphia (Hahnemann Med. Coll. '93), September 7, aged 79.

Sept. 15 Franklin	81	10326	\$23.00
15 Washington	137	10327	23.00
16 Delaware	305-307	10328-10330	34.50
18 Lycoming	144	10331	11.50
18 Montgomery	349-350	10332-10333	23.00
25 Cambria	156	10334	23.00
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The following requests were filled during the month of September:

Collagen diseases	Painful knee
Peyronie's disease	Osteo-arthritis
Mongolism	Circumcision
Chronic nephritis	Urticaria
Herpes zoster	Studies on beryllium
Bronchiogenic carcinoma	Pompholyx
Cystitis	Sex education
Prostatitis	Uveoparotitis
Studies on uric acid	Low salt syndrome
Healing arts	Diseases of pubic bone
Gastrojejunal ulcers	Loeffler's syndrome
Prevention of blindness	List of archives
Diseases of the gallbladder	
Fascial sarcoma invading bone	
Pneumonitis and anthracosilicosis	
X-ray therapy in Hodgkin's disease	
Method for determining blood volume	
Management and treatment of bronchiectasis	
Celiac disease in children	
Treatment of leg ulcers (2)	
Pulmonary mycotic infections (2)	
Fluorides in prevention of dental caries	
Techniques of cesarean section	
Staphylococcus aureus infections	
Escherichia coli infections	
Conditions of the thymus	
Anesthesia in fluoroscopic rooms	
Home visitation and home care	

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Aug. 31 Greene	28	10305	\$23.00
Sept. 8 Westmoreland	209	10306	23.00
9 Lawrence	83-84	10307 10308	23.00
10 Philadelphia	3054 3069	10309-10324	368.00
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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

FATE has challenged physicians in a peculiar way with respect to primary cancer of the lung. Of all internal cancers, those originating in the lung should be the most readily discovered while still locally confined. Not only can the lesions be found but they can be properly labeled. Excision of the cancer-bearing lung has been shown to be feasible, relatively safe, and effective. Physicians, therefore, have the tools with which to find, label, and successfully treat cancer in this location.

SILENT PHASE OF CANCER OF THE LUNG

Cure of cancer of the lung was never seriously considered prior to 1933, when total excision of the lung was shown to be possible. During subsequent years, correlated studies of symptoms, roentgenographic shadows, bronchoscopic observations, cellular elements of sputum, and surgically detected pathologic conditions have been made. Much is now known as to the life history, direction of spread, and variabilities of the several histologic types of cancer of the lung. Sufficient time has elapsed to find from the literature a mounting list of recorded five-year cures. It has been shown that cure rates are high if the patients submit to pneumonectomy at a time when there is no demonstrable growth outside the lung. Those patients who were saved by pneumonectomy have been able to enjoy life and have taken a productive position in society.

Since cancers are growths, all extensive lesions were at one time small and localized. To eliminate all delay in the discovery of any cancer is, of course, essential. The average patient waits three months after the onset of symptoms before seeking advice. The record then shows that, by the orthodox methods which physicians use to sort out patients with cancer of the lung from those with other conditions, there is another seven months' delay.

Why has the time schedule been so prolonged? There are four principal reasons:

1. The first and only symptom is usually nothing more than cough.

2. The stethoscope is unreliable because abnormal physical signs are either nonexistent or the same as those encountered with any common chest ailment.

3. Secondary infection is frequent during the symptoms' phase and becomes a "red herring" leading to misdiagnosis and misdirected treatment, usually for recurring colds, chronic bronchitis, or virus pneumonia.

4. Abnormal areas of density in the conventional roentgenogram of the chest are extremely variable because of bronchial occlusion of the segmental or subsegmental bronchi. The anatomic arrangement of the pulmonary segments permits a wide range of possible shadows, depending on the relative position and superimposition of the aerated to unaerated segments.

Since the orthodox method of case-finding depends on a lesion extensive enough to produce symptoms, and since the signs are so variable and confusing, it is obvious that delays in definitive treatment are bound to occur. The same situation developed in regard to case findings in tuberculosis. By depending on a warning symptom, visits to the physician, therapeutic trials, and eventually the true diagnosis, the disease in about 85 per cent of all persons with tuberculosis

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our
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1. Internat. Abstr. Surg. 83:1, July 1946.

2. Am. J. Obst. & Gynec. 49:114, Jan. 1945.

3. J.A.M.A. 128:1152, Aug. 18, 1945.

had progressed to advanced stages. Case finding of the presymptomatic or silent lesion by the mass survey method has reversed the ratio of minimal to advanced cases, and a yield of 85 per cent of minimal cases is discovered.

Detectability of Cancer of the Lung

Cancer of the lung has a silent phase and is detectable. The air within the expanded lung provides a natural contrast medium for the detection of changes in density. Small tumors growing in the periphery will cast a direct shadow. Smaller tumors centrally located cause a subsegmental or segmental bronchial obstruction, which will cast a shadow of the corresponding atelectatic segment. An airless segment will cast a shadow many times the size of the shadow of the tumor itself; thus there is actual magnification of centrally placed lesions which represent the great majority of all pulmonary cancer. This is fortunate, as small tumors within the pulmonary hilus might otherwise escape detection because of the growing of normal bronchial and vascular shadows in this area.

The case-finding program in tuberculosis is already performing a double service as the incidental finding of silent cancer has shown. Patients with suggestive abnormal areas of density apparent in a survey film have been observed; on exploratory operation these densities sometimes prove to be cancer. Although the discovery of cancer in tuberculosis survey programs has not produced startling figures, the follow-up of all suspect cases has been incomplete.

The Length of the Silent Phase

Rates of cancer growth vary, but there are isolated instances in which abnormal shadows existed for several years and yet on surgical exploration the lesion was found to be apparently localized. Exploratory operations also have been known to reveal extensive metastases. This in no way mitigates the value of screening unless recent roentgenograms were normal. If the survey roentgenogram represents the first and only roentgenogram the patient ever had taken, who will deny that, if the person had been having annual examinations previously, cancer in an operable stage probably could have been discovered. It is impossible to say how often patients should be screened in order to give reasonable protection from cancer of the lung. As further experience develops, this point can be determined. For the present, selective screening on an an-

nual basis would seem to be wise. The highest yield will be among men over 45 years of age.

Need for Proper Labeling

Screening the whole population and spotting abnormal pulmonary densities is the first step. Prompt and adequate investigation of suspects is equally important. Additional information can be obtained by positional, stereoscopic, tomographic roentgenologic studies, cytologic examination of sputum, bronchoscopy, and exploratory thoracotomy. Negative sputum or negative bronchoscopic examination does not prove the nonexistence of cancer. If the abnormal roentgenologic density cannot be explained with reasonable certainty on any other basis, surgical exploration should be advised. Fortunately, today this can be done with safety. With the chest open and the lung under direct inspection and palpation, the lesion which caused the abnormal shadow can be readily located. Lesions near the surface and many in the hilar area can be directly biopsied. If the lesion is located centrally, within a segment or subsegment, and direct biopsy is considered not to be technically easy, then the segment or subsegment bearing the mass should be removed. The best cancer operation, here as elsewhere, is one which follows the principle of the widest possible excision of the cancer-bearing organ with all the regional lymphatic vessels.

Conclusions

(a) Orthodox methods of case finding based on symptoms have produced a low yield of localized pulmonary cancers. (b) A silent phase of cancer of the lung exists and is detectable by periodic radiologic screening. Survey methods developed for tuberculosis case-finding may do a double service. The highest yield of silent cancer will be found in the male population of 45 years and over. (c) The labeling of survey-found abnormalities must be prompt and exact. Although time lags in tuberculosis follow-up may not prove to be fatal, time lags may cost patients their lives if cancer occurs. (d) Surgical exploration in cases in which cancer is suspected will establish the exact diagnosis and will permit immediate excisional therapy, which for most will be curative.

Silent Phase of Cancer of the Lung, Richard H. Overholt, M.D., and Ivan C. Schmidt, M.D., J. A. M. A., Nov. 19, 1949.

THE WOMAN'S AUXILIARY

MRS. PAUL C. CRAIG, *Editor*

232 North Fifth Street, Reading

THE PROBLEM OF MEDICAL RESEARCH

If 85 per cent of the American people had their way, the most pressing problem in medical research would cease to exist. This overwhelming majority have expressed their approval of the humane use of animals in research experiments. Yet in state after state the passage of a "pound law" which would permit the use of unwanted and unclaimed animals, particularly dogs and cats, in such experiments has been repeatedly blocked by the efforts of a small, highly organized minority of misguided and misinformed individuals.

A "pound law" failed to pass in the 1949 session of Pennsylvania's General Assembly. According to an editorial in the *Pittsburgh Press*, one legislator, when questioned concerning the reason for the bill's defeat, answered that he personally favored the bill and felt that the vast majority of his constituents did also. However, he had received a flood of letters against the bill and not a single letter favoring it. He had, therefore, voted against it. His response is doubtless typical of the legislators not only in Pennsylvania but in other states where similar legislation has failed.

It is difficult to determine just who makes up the opposition to animal experimentation and where they secure their misinformation. With a few exceptions, leaders molding public opinion have heartily endorsed the position of the medical profession and others sincerely interested in promoting the welfare of mankind through the use of animals in research.

Perhaps the most potent argument put forth by those opposing animal experimentation is the disappearance of a beloved pet through "dog napping" and the "gray market." Obviously those responsible for securing animals to be used in medical research cannot be expected to trace the source of every animal offered to them and doubtless such cases do occur.

The point is that the passage of a "pound law"

would wipe out this practice by eliminating the possibilities for profit in the traffic of pets. There is ample evidence to indicate that the unclaimed and unwanted dogs who die in the gas chambers of city pounds would adequately supply the needs of medical research.

The "antivivisectionists," a smaller group within the minority, apparently are willing to sacrifice the progress of humanity at the altar of a blind fetish. How many of them are vegetarians? What do they think about the gas chamber? Do they know that 90 per cent of the research experiments in which animals are used do not involve pain or death? Do they know of the meticulous efforts to eliminate or alleviate pain in connection with such laboratory work for the sake of mankind? In the final analysis, how many of them would plead for the life of a dog at the expense of the life of a child?

The Medical Society of the State of Pennsylvania is determined to make every legitimate effort to secure the passage of a "pound law" by the 1951 session of the Pennsylvania General Assembly. There can be no doubt that this clear objective constitutes a crusade for the sake of humanity. The 1948 House of Delegates placed in the capable hands of the Woman's Auxiliary the responsibility for carrying out a program of public education on the subject of animal experimentation in medical research. This is a responsibility which every member of the Woman's Auxiliary should accept gladly and with a full knowledge of its high purpose.

It is imperative that no Pennsylvania legislator in 1951 shall be able to make the same statement that was quoted above after the 1949 session. To prevent this, it is essential that every auxiliary member, fully armed with the facts, go forth to combat ignorance and misinformation, using all means of communication to fully inform the people of Pennsylvania as to (1) the vital importance of an adequate supply of animals for medical research and (2) the need for political action in support of medicine's

position. We know that we have the implicit support of the majority. Our task is to make that support explicit and definite—an overwhelming flood tide of public opinion favoring the passage of Pennsylvania's pound law in 1951.

ALLEN W. COWLEY, M.D., *Chairman,*
Committee on Public Relations,
The Medical Society of the State of
Pennsylvania.

A TRIBUTE TO OUR THIRD HONORARY MEMBER

"If we work upon marble, it will perish; if on brass, time will efface it; if we rear temples, they will crumble into dust; but if we work upon immortal minds, and imbue them with principles, with the just fear of God and love of our fellowmen, we engrave on these tablets something that will brighten to all eternity."

These words of Daniel Webster grace the frontispiece of the first yearbook of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, then launching on its seventh year of operation. The vision of the pioneers of 1924 had been translated into reality, and their



Mrs. W. Wayne Babcock, founder and organizer of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, who was elected to honorary membership at the Philadelphia convention.

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CONTEST ENDS JANUARY 31, 1951

great faith and perseverance had helped the new organization to withstand the difficulties—lack of sympathy, skepticism, even open antagonism—of those first years of existence and growth.

For the ideals which she cherished and brought to fruition with enthusiasm that caught fire in many a soul and by the dynamic force of her organizing ability, we honor Mrs. W. Wayne Babcock and confer upon her honorary membership in the organization which exists today because she and her colleagues struggled with determination to make a dream come true.

In 1923 Mrs. Babcock attended the meeting of the newly formed Woman's Auxiliary to the American Medical Association in California. In Reading, in 1924, she spoke before the House of Delegates of our State Medical Society and was granted unanimous permission to organize an auxiliary in Pennsylvania.

That was the beginning of years of activity in national and state auxiliaries. Highest honors might have been hers, but Mrs. Babcock chose for the most part to work indirectly by persuasion and example. Serving with distinction

as chairman of various committees, notably as national organization chairman in 1928, she only once assumed top leadership in helping to carry on in the regime of Mrs. Walter Jackson Freeman of Philadelphia.

Mrs. Babcock is the wife of the eminent Philadelphia surgeon, Dr. W. Wayne Babcock, and is the mother of four children. She was born Marion Walters in Swarthmore, and attended Swarthmore and Wellesley Colleges, later teaching in public schools.

With her husband she shares an ardent interest in sports and is a member of the American Trapshooting Association and of many local and state shooting clubs. Some years ago, following an operation on her right eye, Mrs. Babcock won the state championship despite the handicap of changing from right- to left-hand shooting.

Another of her varied interests is in the field of art. She has been accorded considerable acclaim as a sculptor and artist in her own right, and has established herself as a patron of all the arts. Her Chinese art collection is outstanding.

Mrs. Babcock has traveled extensively—in fact, returned just recently from a tour of the Latin and South American countries—but has

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GYNECOLOGY—Intensive Course, two weeks, starting February 19. Vaginal Approach to Pelvic Surgery, one week, starting March 5.

OBSTETRICS—Intensive Course, two weeks, starting March 5.

RADIATION PHYSICS—Intensive Review Course, four days, starting November 29.

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always found time for participation in many civic enterprises. During World War II she was a member of the Nurses' Aide Corps, and retains her interest in the work of the American Red Cross.

As she wrote in 1928, when national Chairman of Organization, "So often it is true that the generation that enjoys the shade of the oak did not plant the acorn." Happily Mrs. Babcock, who more than a quarter century ago helped to plant the acorn, having the faith to believe in its possibilities, can now enjoy the shade of an adult, expanded organization. We bless her for the sincere conviction and selfless love that were poured into her work as a founder of our Pennsylvania Auxiliary.

(MRS. FRANCIS F.) VIOLA BORZELL,
Councilor of First District.

MRS. W. WAYNE BABCOCK

At the twenty-sixth annual convention of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, Mrs. W. Wayne Babcock, organizer of the Auxiliary, was proposed for honorary membership by Mrs. Paul C. Craig, chairman of the Nominating Committee, and unanimously elected. No one present will ever forget Mrs. Babcock's response as she told of the early days of our organization.

A token expression of love and gratitude was presented to Mrs. Babcock on behalf of the Auxiliary by Mrs. Frank P. Dwyer in these words:

"DEAR MRS. BABCOCK:

"I am happy that I was chosen to welcome you into this select Honor Society and to extend to you the admiration and esteem of its two members, as well as the admiration and esteem

of the whole Auxiliary body who have honored you today. We welcome you, not only as a new member but as our Honor Society treasurer. We have a president, self-appointed, and a secretary appointed by the president, but we did need a treasurer, just like other well-regulated organizations.

"You will have nothing tangible to hold fast, but we know you will always treasure the affection and gratitude of the 4300 members of the Auxiliary. You will forever treasure the power and force you let loose when you effected the organization of the Auxiliary. One of the great treasures of your Auxiliary memories will be the knowledge that the three aims of the organization you founded are still the cornerstones of the Auxiliary today. Help in medical meetings, help in legislative matters, and friendliness among doctors' wives are as much our program today as they were when you went about the State expounding them.

"It will be your treasure of memories to know that your plea through the years 'keep it friendly' still rings in all our hearts. Your dream has come true in noble fashion.

"And so that, as treasurer of memories, you may be legal, as well as honored, here is your bond, all signed and in order, with the esteem and the gratitude of the entire Auxiliary membership."

Postscript to a notable day: "I came home after the long worth-while drive to Longwood Gardens, thrilled and warm inside over a memorable day—one that I will pack away with the choicest treasures of my career. The lovely pin selected with such understanding of my taste—the recurring picture of all those earnest women working together for a common cause allied with their husbands' profession, all served to push me up in a rarified atmosphere. It was too much to have happened all at once."—MARION BABCOCK.

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WILLIAM HARVEY PERKINS, M.D., *Dean.*

BYSTANDERS ARE NOT INNOCENT

You may feel that this is a peculiar title, but you will admit that it is an intriguing one. I can well say this, for it is not original with me. It was the title of an article written by Norman Cousins for the *Saturday Review of Literature* some time last year. Ever since I read the title I have had a desire to use it for an article, and I hope you will bear with me while I indulge in this desire.

So many people feel that if they stand by and do not take sides on an issue they are innocent; but, if one stops to think, sins of omission are just as bad as sins of commission. To apply this to our membership: We as doctors' wives are more or less in the limelight and what we do or do not do is reflected for good or bad on our husbands and more or less on the entire medical profession. If in the November election a wife of a physician stood apart and did not encourage people to register and vote, she would be partly at fault if the desired results were not obtained. Someone has said that the reward of a thing well done is to have done it. I hope this applies to your membership; and, judging by the auxiliary women of your state with whom I have been fortunate enough to work, I know it does apply to some of you at least.

This year we shall continue our efforts to procure resolutions. The study kits prepared by Whitaker & Baxter for our use are ready. Carry this information to other women's groups of which you are an active member. I refer to such groups as the American Association of University Women, League of Women Voters, parent-teacher associations, all nursing groups, and many others. These organizations generally precede action by study. Offer them these kits, for I feel that if they understand the issue of

voluntary health insurance versus compulsory health insurance, they will be for the voluntary way, which is, of course, the American way. Do not be timid or hesitant in your approach, for what you are offering is of vital importance in the life of every American citizen.

The international situation should arouse all of us to action and should eliminate all bystanders. Every doctor's wife should actively participate in all phases of the civilian defense program. Let the people of your state know that you are ready and eager to be a part of any program that will protect the health and welfare of the public.

Our membership is now over 54,000, but we should and could have twice that many members if every doctor's wife could be made to realize that she is needed and wanted as an active, alert member.

Jefferson said, "I like the dream of the future better than the history of the past." I hope our dream of the future, which is, of course, every eligible doctor's wife an active, interested member, will soon come true; then we shall have no bystanders and there will be no point in discussing whether or not they are innocent.

(MRS. ARTHUR A.) EDA S. HEROLD,
President,
Woman's Auxiliary to the American
Medical Association.

PRIZE ESSAY CONTEST

The American Dermatological Association is offering a prize of \$300 for the best essay submitted of original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields.

Manuscripts typed in English with double spacing as for publication, together with illustrations, charts, and



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tables, are to be submitted in triplicate not later than Feb. 1, 1951, and should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Ave., Southwest, Rochester, Minn.

Competition in this prize contest is open to scientists generally; not necessarily physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. This contest is planned as an annual one, but if in any year, at the discretion of the Research Aid Committee and judges, no paper worthy of a prize is offered, the award may be omitted.

The prize-winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the \$300 prize. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be the Diamond Jubilee Observance of its founding and will be held May 23-26, 1951, at the Homestead, Hot Springs, Va.

ABOUT THE ARMY MEDICAL SERVICE

Medical Corps Officer Classification

FRED J. FIELDING, *Lieutenant Colonel, M.C., U. S. A.*¹

The Medical Corps officers' classification policy was revised on June 27, 1950. In general the criteria for the award of the various prefixes used with Military Occupational Specialty (MOS) numbers to indicate proficiency have been tightened. It is believed the new criteria will be a better guide to commanders in the field in making assignments that will give the officer an opportunity of performing on the highest level for which he is qualified.

Alphabetical prefixes denoting degree of proficiency have not been established for use in connection with Medical Officer, Command (3500) and Medical Officer, Staff (3000). There is only one professional progression pattern under the career guidance program of the Medical Service for these two MOS's. Therefore, while following one specialty, ample opportunity is provided for necessary experience in the other and at times the staff officer performs additional duties of Medical Officer, Command, as in the case of a post surgeon who also commands the station hospital of the post. In the higher levels of these positions the assignments are correlated with rank and past military experience. The officers selected must have demonstrated outstanding ability in medico-military administration and have had extensive staff and command experience. Officers with a primary classification in a professional field will be changed immediately to a primary staff or command classification when ordered to such duty, provided that

it has been determined that the future career of the officer will continue along staff or command channels. Some such officers may continue to carry their professional classification as a secondary MOS.

For the professional MOS's the following changes have been made in the criteria for the D, C, and B prefixes.

Group D prefix now will be awarded only on the completion of 12 months' residency or fellowship in all specialties rather than under the old policy where officers in many of the specialties could receive D prefix 6 months after residency training. Likewise, officers without formal training will now require, for all specialties, 18 months of duty limited to the professional field instead of the 12 months formerly required for many specialties. One exception to this criterion is the award of certain secondary subspecialty classifications to officers already qualified as A, B, or C internists or surgeons.

Group C prefix will now be awarded only to officers who have recently completed the formal training required to meet the American Board requirements for certification; whereas, in the past, officers have been awarded a C prefix after completion of 2 years' residency training. This will mean that now an officer will not receive his C prefix until after completion of 3 years of formal training in the major specialties. Likewise, officers without the formal training required must have professional duty or practice limited to the professional field for a minimum of 5 years for all specialties prior to the award of C prefix. In the past this required period has varied from 3 to 5, 4 to 6, or 5 to 9 years, depending on the specialty involved. Again exceptions are made in regard to the award of a C prefix in secondary subspecialties for officers already qualified as A, B, and C internists or surgeons.

Group B prefix, in the future, will indicate that the officer has been certified by the American Specialty Board for his particular classification. Officers who have been awarded the B prefix without a board certification will continue to retain this prefix designation as long as their performance of duty indicates continued ability to function in the specialty without professional supervision.

Group X.—For the first time a new prefix appears in the medical officer classification policy. This prefix is an indication that the officer to whom it is awarded has qualifications in research that are associated with the specialty field identified by his MOS. The need for some specific designation of officers qualified or trained in research has been recognized by this office for a considerable period. An attempt has been made to establish a specific MOS for this type of officer, but technical difficulties and other problems have precluded such an MOS being established. In lieu thereof, the Surgeon General's Office was authorized to use the prefix system to designate an officer qualified or engaged in research. This has been done now by the establishment of the prefix X.

The new classification policy also defines for the first time the prefix designation identifying the degree of proficiency for the Radiological Defense Officer (3004). Although the same prefixes X, A, B, C, and D are authorized in connection with this MOS, the

¹ Personnel Division, Office of the Surgeon General, Department of the Army.

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1. Keen, B. B., Rohr, J. R., and Colwell, A. R.: *Proc. House Staff Dept. Med., Wesley Memorial Hospital, Chicago, Ill.* Feb. 6, 1940.

2. Rohr, J. H., and Colwell, A. R., *Proc. Amer. Diabetes Assn.* 37, 1945.

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definition and criteria under which these prefixes are awarded are quite different from those used in connection with other professional MOS's. This difference must be kept in mind when considering the qualifications and degree of experience of medical officers with MOS 3004.

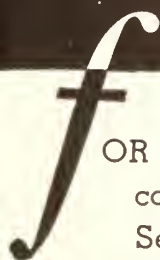
Medical Officer, General Duty (3100) is a basic MOS. It indicates that an officer is qualified to perform various medical functions in a hospital, dispensary, field unit, or other military installation, rather than being limited to one particular field. In addition, it is used to designate the primary classification of officers assigned to duty as interns in either civilian or military hospitals. The alphabetical prefix denoting the degree of proficiency will not be used in connection with MOS 3100.

It is believed that this new change in policy will result in a more efficient classification and utilization of medical officers.—*U. S. Armed Forces Medical Journal*, September, 1950.

The incidence of leukemia—an invariably fatal process at present—is increasing (see page 1172).

The very first thing for a man to realize is that the world does not owe him a living. It owes him nothing except for value received. And his first business in the world is to do something to help the world along, and only in this way can he justify his existence and have a decent excuse for consuming food and oxygen.—Dr. FRANK CRANE.

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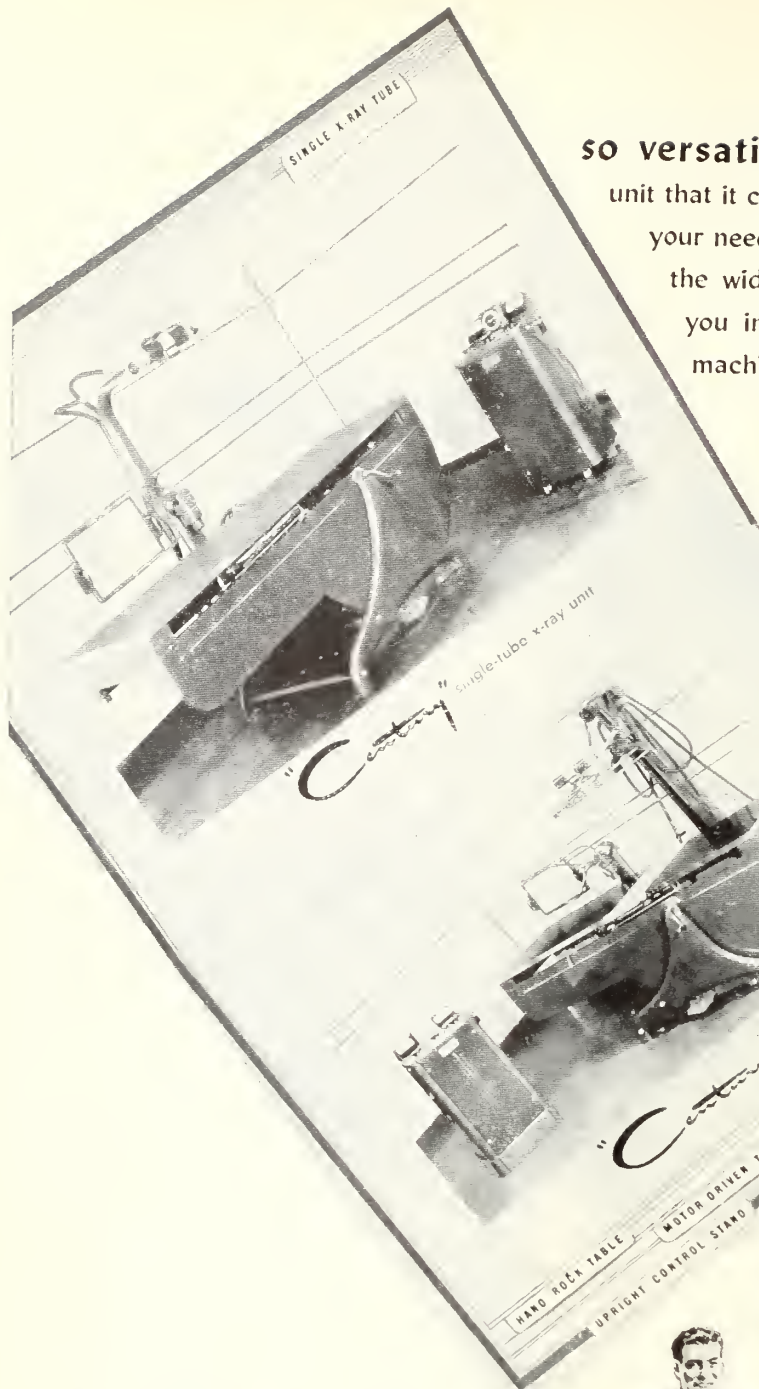
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**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 61-65, No. 11, 590-592;
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1957, Vol. XLVII, No. 1, 58-60



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MEDICAL NEWS

Births

TO DR. AND MRS. ALFRED STENGEL, JR., of St. Davids, a son, James Lyman Stengel, October 6.

TO DR. AND MRS. LOUIS E. BROGAN, of Philadelphia, a daughter, Anne Christine Brogan, September 16.

Engagements

MISS NANCY LEE KNOWLTON, of Radnor, to Henry Dennis Cornman, 3d, M.D., of Gladwyne.

MISS FRANCES JOYCE GLASS, of Harrisburg, to Leslie Byron Silverstine, M.D., of Bradford.

MISS MARGARET LUCILLE WILLIAMS, daughter of Dr. and Mrs. Roy G. Williams, of Media, to Lt. Com. John Boyd Flynn, USNR.

MISS GERALDINE IRIS SMITH, of Glen Ridge, N. J., to Mr. Grant H. Keeler, son of Dr. and Mrs. Harold R. Keeler, of Drexel Hill.

MISS MARY ISABELLA HERNDON, of Wilmington, Del., to Mr. William Dickie Ravdin, son of Dr. and Mrs. I. S. Ravdin, of Philadelphia.

MISS JANET LEE ZIFFERBLATT, of Philadelphia, to David Robert Brody, M.D., of Youngstown, Ohio, who is senior surgical resident at the Jewish Hospital, Philadelphia.

Marriages

MISS ANN DOUGLAS WILSON, of Pittsburgh, to Lloyd Lyman Lancaster, M.D., of Wayne, October 14.

MISS ROSEMARY NORRIS LYNCH, of Wynnewood, to George Doring Ludwig, M.D., of Johnstown, October 14.

MRS. MARTHA THOMAS LYTLE, of Asheville, N. C., to John Robinson Hoskins, 3d, M.D., of West Chester, September 16.

MISS CLARA MELISSA MARSH, of Haverford, to Mr. Joseph Evans Sands, 3d, son of Dr. and Mrs. Joseph E. Sands, 2d, of Rosemont, October 28.

MISS SUZANNE PHILLIPS, daughter of Dr. and Mrs. Thomas W. Phillips, of Media, to Mr. Miles Martin Isaacs, Jr., of Georgetown, Del., October 1.

MISS MARTHA ELIZABETH CALHOUN, of Chestnut Hill, to Mr. Edward White Jones, 2d, son of Dr. and Mrs. Clifford B. Jones, of Philadelphia, October 7.

MISS BETTY-TERRY WOOD, daughter of Dr. and Mrs. Charles T. Wood, of Prospect Park, to Mr. Walter Raymond Dewees, Jr., of Wilkes-Barre, October 28.

MISS PAULINE BEIN REIMANN, daughter of Dr. and Mrs. Stanley P. Reimann, of Philadelphia, to Mr. George Young Nehrbas, of Bryn Mawr, October 14.

MISS NORMA MARGARET ALESBURY, daughter of Dr. and Mrs. James M. Alesbury, of Philadelphia, to Mr. Edwin Joseph Kelley, of Syracuse, N. Y., October 21.

MISS PAULINE TILAYER TALBOTT, of New York and Westbury, L. I., to Ensign Owen Jones Toland, U.S.N., son of Dr. and Mrs. Owen J. Toland, of Wynnewood, October 3.

MISS ANNE MOFFLY LANDENBERGER, of Chestnut Hill, to Mr. Thomas Williams Smyth, son of Mrs. Williams Smyth and Calvin M. Smyth, Jr., M.D., of Philadelphia, October 7.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ **Frederic H. Lewey**, Philadelphia; Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Prussia, 1908; aged 65; died Oct. 6, 1950, of coronary thrombosis. He was professor of neuro-anatomy in the Graduate School of Medicine at the University of Pennsylvania and associate professor of neuropathology in the School of Medicine. Dr. Lewey was born in Germany and was professor of neurology and director of the Neurological Institute of the medical school there. During World War I, he served as a medical officer with the German Army in Turkey. In 1933 he came to the United States. During World War II, Dr. Lewey served as a lieutenant colonel in the U. S. Army Medical Corps, acting as chief of neurology at the Cushing General Hospital, Framingham, Mass., and as consultant to the surgeon-general of the Army. Last year Dr. Lewey returned from South America with a new silver staining technique for examining brain tumors. It was developed by a Spanish physician and gives a better outline of the cells and fibers than was previously possible. Dr. Lewey is survived by his widow.

○ **Newton W. Hershner**, Mechanicsburg; University of Maryland School of Medicine, 1906; aged 72; died Oct. 8, 1950, after a two weeks' illness following a heart attack. Dr. Hershner was medical director of Cumberland County for many years and was active in civic affairs. He served on the board and was president of the medical staff of Seidle Memorial Hospital in Mechanicsburg for many years. He was also on the staff of Carlisle Hospital. He was a past president of the Cumberland County Medical Society; he was district censor for his county society and had been re-elected a delegate to the annual meeting of the State Medical Society in Philadelphia in October. Surviving are his widow and two sons, one of whom, Dr. Newton W. Hershner, Jr., also practices in Mechanicsburg.

○ **Russell A. Garman**, Jeannette, Jefferson Medical College of Philadelphia, 1930, aged 46, was shot and killed Oct. 1, 1950, by a former patient, in failing health and despondent, who then killed himself. Dr. Garman was a specialist in internal medicine and his ability was highly regarded by his medical and hospital associates.

He devoted much time to graduate study in the large medical centers. He was on the staff of Westmoreland Hospital and was actively interested in the establishment of the new hospital in Jeannette. In 1948-49 Dr. Garman was president of the Westmoreland County Medical Society. After 28 months' service with the Navy during World War II, he was relieved of active duty with the rank of lieutenant commander. His widow and three sons survive.

○ **Joseph V. Connole**, Wilkes-Barre; Jefferson Medical College of Philadelphia, 1912; aged 61; died Oct. 15, 1950, following a heart attack. Dr. Connole, a specialist in eye, ear, nose and throat diseases, was a member of the staff of Mercy Hospital for 30 years and was consultant at Nesbitt Memorial Hospital in Kingston. He retired in 1947 and his practice was taken over by his nephew, Dr. John F. Connole. During World War I, Dr. Connole served in the Navy. In 1941 he was president of the Luzerne County Medical Society. He was a member of the American Academy of Ophthalmology and Otolaryngology and a Fellow of the American College of Surgeons. Three sisters survive.

○ **Louis H. Mutschler**, Merion; University of Pennsylvania School of Medicine, 1895; aged 78; died Oct. 2, 1950. During his career Dr. Mutschler held staff positions at the old Orthopedic Hospital in Philadelphia, the Infirmary for Nervous Diseases, and St. Christopher's Dispensary. Until his retirement from the post in 1931, he was for many years chief surgeon at the Episcopal Hospital. After retiring he served in an advisory capacity at Episcopal. He was a Fellow of the American College of Surgeons. Surviving are his widow, a son, a brother, and two sisters.

○ **Thomas J. Cush**, Johnstown; Jefferson Medical College of Philadelphia, 1924; aged 49; died suddenly Sept. 30, 1950, as he was about to treat a patient. He was president of the Cambria County Medical Society. Dr. Cush was head of the orthopedic department at Mercy Hospital. He had served on its surgical staff since 1929. He was also a member of the reserve surgical staff of Memorial Hospital and a Fellow of the American College of Surgeons.

○ **Robert W. Brown**, Greenville; University of Illinois College of Medicine, Chicago, 1892; aged 84; died Oct. 18, 1950, following a year's illness. In 1942 Dr. Brown was honored by the State Medical Society for having practiced 50 years. He was local surgeon for the Erie Railroad and a member of the board of directors of Greenville Hospital. Three daughters and two sons survive, also a brother and a sister.

George S. Wallace, Marianna; Jefferson Medical College of Philadelphia, 1897; aged 81; died Sept. 27, 1950, in Florida where he had gone last February to make his home. He had practiced medicine for 51 years and was a veteran of three wars—Spanish-American, Philippine Insurrection, and World War I. He resigned his membership in the Washington County Medical Society in January, 1950.

Leo J. Laux, Philadelphia; University of Pennsylvania School of Medicine, 1917; aged 55; died Oct. 23, 1950. Dr. Laux was a native of Sayre. During

World War I, he served in the Army Medical Corps. Since 1944 he had been a rating specialist with the Veterans Administration. He is survived by his widow, a son, and three daughters.

Paul O. Messner, Cambridge Springs; College of Medical Evangelists, Loma Linda-Los Angeles, Calif., 1934; aged 48; died Oct. 4, 1950, in Miami Springs, Fla., where he had been living recently. During World War II, he served in the Air Force in the European theater. He is survived by his widow, two sons, and two sisters.

○ **Arno C. Voigt**, Hawley; Jefferson Medical College of Philadelphia, 1901; aged 72; died Sept. 20, 1950, following an illness of several months. Dr. Voigt was president of the First National Bank of Hawley. His son, Dr. George B. Voigt, is a resident physician at Wilkes-Barre General Hospital.

○ **Almon C. Hazlett**, Wyoming; Jefferson Medical College of Philadelphia, 1913; aged 59; collapsed Oct. 17, 1950, while driving his car in Philadelphia and died 20 minutes later. He was attending the annual convention of the State Medical Society. Dr. Hazlett specialized in obstetrics.

James C. Rogers, Bellefonte; University of Pennsylvania School of Medicine, 1905; aged 68; died Sept. 29, 1950. He is survived by his widow, four daughters, and two sons, one of whom, Dr. Hugh J. Rogers, also practices in Bellefonte.

○ **Frank B. Baird**, Philadelphia; University of Pennsylvania School of Medicine, 1907; aged 72; died Oct. 23, 1950, after a long illness. He was team physician for the Athletics for 22 years until 1937. His widow and two stepsons survive.

○ **Margaret I. Cornelius**, Beaver; University of Pittsburgh School of Medicine, 1909; aged 72; died suddenly Oct. 6, 1950, of a heart attack. Dr. Cornelius had served as Beaver County medical director for many years. Two sisters survive.

○ **John W. Horn, Jr.**, Hummelstown; Temple University School of Medicine, 1917; aged 63; died Sept. 29, 1950, of a heart attack while driving his car. He is survived by his widow and a son.

Kenneth V. Lowe, New Kensington; University of Pittsburgh School of Medicine, 1933; aged 42; died Oct. 15, 1950, after an illness of several years. His parents and a sister survive.

Ella M. Gerlach, Philadelphia; Woman's Medical College of Pennsylvania, 1898; aged 82; died Oct. 5, 1950. She had practiced medicine for 52 years.

Paul H. Gerhardt, Mt. Gretna; Hahnemann Medical College and Hospital of Philadelphia, 1908; aged 70; died Oct. 13, 1950. His widow and a sister survive.

○ **John E. Barsby**, Quakertown; Jefferson Medical College of Philadelphia, 1920; aged 60; died Sept. 1, 1950. He specialized in ophthalmology.

○ **Guy C. Boughton**, Erie; University of Vermont College of Medicine, Burlington, 1900; aged 73; died Aug. 9, 1950.

○ Charles F. Flannery, New Castle; Eclectic Medical College, Cincinnati, Ohio, 1911; aged 74; died Aug. 28, 1950.

○ Thomas M. Shaffer, New Castle; University of Pittsburgh School of Medicine, 1912; aged 69; died Aug. 16, 1950.

Miscellaneous

WILLIAM L. ESTES, JR., of Bethlehem, a former president of The Medical Society of the State of Pennsylvania, was named chairman of the Board of Governors of the American College of Surgeons on October 23.

A TWO-DAY COURSE ON ACTH AND CORTISONE, covering both the physiologic basic aspects and the clinical use, was held on November 13 and 14 at Jefferson Medical College, Philadelphia. The course was free and open to all physicians.

AT A RECENT MEETING OF THE PITTSBURGH ROENTGEN SOCIETY, the following officers were elected for 1950-51: president, Eva S. Carey, M.D.; vice-president, Lester M. J. Freedman, M.D.; secretary, Edwin J. Euphrat, M.D., and treasurer, Alan R. Brown, M.D.

ELI EICHELBERGER, M.D., of York, was elected president of the Pennsylvania Public Health Association at its one-day annual convention on October 19. Dr. Eichelberger succeeds Dr. Pascal F. Lucchesi, of Philadelphia. The president-elect is I. Hope Alexander, M.D., of Pittsburgh, which city has been selected as the site for the 1951 convention.

THE SIXTY-FOURTH ANNUAL BANQUET OF THE ASSOCIATION OF EX-RESIDENT AND RESIDENT PHYSICIANS OF THE PHILADELPHIA GENERAL HOSPITAL will be held on Tuesday, December 5, at 7 p.m., at the Penn-Sheraton Hotel, 39th and Chestnut Sts., Philadelphia. Reservations may be had by writing to the secretary-treasurer—Robert C. McElroy, M.D., Room 514, 133 S. 36th St., Philadelphia 4, Pa.

IN MEMORY OF THE LATE DR. S. DANA SUTLIFF, of Shippensburg, a medical directory published by the American Medical Association of all the physicians in the United States and its possessions has been presented to the medical library at the Chambersburg Hospital by the Franklin County chapter of the Daughters of the American Revolution. Announcement of the presentation was made by Mrs. Sutliff at the first fall meeting of the Woman's Auxiliary to the Franklin County Medical Society.

THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA announces the publication by Lippincott of a history of the college entitled *The Woman's Medical College of Pennsylvania 1850-1950* by Gulielma Fell Alsop, M.D. Dr. Alsop was graduated from Barnard College in 1903, received her M.D. degree from the Woman's Medical College in 1908, and studied in Vienna in 1910. For four years she was a missionary doctor in Shanghai, and from 1917 to 1948 was the college physician at Barnard College, New York.

AIMS C. MCGUINNESS, M.D., director of the Children's Hospital of Philadelphia, has been named dean

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of the Graduate School of Medicine of the University of Pennsylvania, effective Jan. 1, 1951. Dr. McGuinness, who will retain his position as a senior physician on the visiting staff of Children's Hospital, fills the position made vacant by the resignation of William S. Parker, M.D. Dr. Parker is retiring to devote his time to the practice of surgery. He will continue, however, on the surgical faculty of the Graduate School.

AT CONSIDERABLE EXPENSE your state medical society is preparing for a modernized IBM punch card system of enrolling information about the 16,000 M.D.'s licensed in Pennsylvania. Each of these doctors will receive the essential questionnaire early in December. The 16,000 punch cards are at hand with names and addresses and are paid for. They await only your response and the needed punches, reducing your record taken from the questionnaires to a confidential jargon to be interpreted only by a key system. Please cooperate.

THE SUPREME COUNCIL, THIRTY-THIRD DEGREE, OF THE ANCIENT ACCEPTED SCOTTISH RITE OF FREEMASONRY FOR THE NORTHERN MASONIC JURISDICTION, comprising the states north of the Ohio River and east of the Mississippi River, has appropriated \$1,000,000 to

endow a benevolent foundation, and the endowment fund will be increased from time to time. A sum of \$50,000 was appropriated for further research into dementia praecox. The Supreme Council launched its dementia praecox program 18 years ago and to date has expended \$900,000 in the work. Richard A. Kern, M.D., of Philadelphia, is chairman of the Committee on Benevolences of the Supreme Council.

THE 106TH MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held September 12 and was a joint meeting with the Berks County Medical Society. The meeting featured a Symposium on Bacterial Allergy with the following speakers and topics: The Present Status of Bacterial Allergy, by Louis Tuft, M.D., Philadelphia; Bacterial Allergy in Otorhinolaryngology, by Russell C. Grove, M.D., New York City; The Role of Allergy in Rheumatic Fever, by John E. Gregory, M.D., Philadelphia; Tubercular Allergy, by Archibald R. Judd, M.D., Hamburg. Paul C. Craig, M.D., Reading, was moderator.

The 107th meeting of the society was held on October 25, when a study club was conducted on the topic of "Ocular Therapeutics" by James H. Parker, Jr., M.D., Reading, and Joseph V. M. Ross, M.D., Berwick.

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1. *Withering*, W.: An account of the Foxglove, London, 1785.
2. *Rimmerman*, A. B.: Digilanid and the Therapy of Congestive Heart Disease, *Am. J. M. Sc.* 209: 33-41 (Jan.) 1945.

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The officers of the society for the year 1950-51 are: president, Roy Deck, Lancaster; first vice-president, William J. Hertz, Allentown; second vice-president and president-elect, Harold L. Strause, Reading; treasurer, Philip R. Wiest, Reading; secretary, Benjamin F. Souders, Reading; program chairman, John E. Keller, Reading.

THE INSTITUTE OF INDUSTRIAL HEALTH OF THE UNIVERSITY OF CINCINNATI will accept applications for a limited number of fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of industrial medicine. Candidates who complete satisfactorily the course of study will be awarded the degree Doctor of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily two years of residency (including internship) in a hospital accredited by the American Medical Association, may apply for a fellowship in the Institute of Industrial Health. The course of instruction consists of a two-year period of intense preliminary training in the basic phases of industrial medicine followed by one year of practical experience under adequate supervision in industry. During the first two years, the stipends for the fellowships vary from \$2,100 to \$3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

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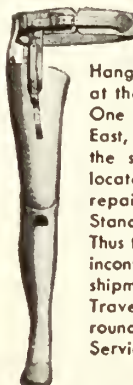
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BOOK REVIEWS

Modern Practice in Dermatology. Edited by G. B. Mitchell-Heggs, O.B.E., M.D., F.R.C.P., Physician-in-charge, Skin Department, St. Mary's Hospital and Medical School, London; Physician, St. John's Hospital for Diseases of the Skin and Institute of Dermatology, University of London; Member, Advisory Panel on Dermatitis, Ministry of Labour and National Service. First edition. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1950. Price, \$12.50.

This book has some fifty contributors and discusses and describes most skin conditions. It is well illustrated. The chief advantage of the present volume is the broad coverage by many well-qualified dermatologists. It is far too extensive and comprehensive to attempt a detailed review, but the points of view of men other than American dermatologists will be interesting and sometimes valuable and instructive for the American reader.

The Management of Obstetric Difficulties. By Paul Titus, M.D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Shadyside Hospital, Pittsburgh; Secretary of the American Board of Obstetrics and Gynecology; Member, Reserve Consultants Advisory Board, Bureau of Medicine and Surgery, United States Navy (Captain, MC, USNR). With 446 illustrations and 9 color plates. Fourth edition. St. Louis: The C. V. Mosby Company, 1950. Price, \$14.00.

This volume occupies perhaps the most prominent position in the library of most obstetricians. For this reason it needs very little introduction. The interesting feature, however, is that Dr. Titus saw fit to bring out a fourth edition of this valuable work. Since the appearance of the third edition in 1945, there have been an unusual number of changes and developments in obstetric practice. Most of the newer procedures that were available only in monograph form are now carefully edited and incorporated in this new edition. Many of the new developments in sterility studies and the management and treatment of threatened and habitual abortions and the newer views on treatment of hemorrhage and shock will be found in this revised edition. There are some interesting changes in the plan of labor induction and in the treatment of retained placentas. Also, all of the newer methods of analgesia and anesthesia are discussed.

One outstanding feature of this new edition is the uniformity of nomenclature and definition agreed upon by Dr. Nicholas Eastman, who has just completed the 1950 edition of Williams' *Textbook of Obstetrics*, and by Dr. J. P. Greenhill, the author of *De Lee-Greenhill's Principles and Practices of Obstetrics*. This will help greatly in the analysis of statistics and in the understanding of procedures as they are found in the various outstanding works on obstetrics.

For the benefit of those who have had no contact or experience with this valuable book, the following description is in order: The volume is 1046 pages in length and is punctuated by 446 clear-cut illustrations and drawings. It is divided into 8 sections. The first section devotes two chapters to the discussion of sterility. This is followed by two chapters which discuss in detail the difficulties and diagnosis of pregnancy. The third section is concerned with the complications of pregnancy. It is made up of 11 chapters and covers virtually every possible complication of pregnancy. The fourth section is a discussion of the complications of labor. It, too, embraces 8 chapters which cover dystocias of all types, intrapartum and postpartum hemorrhage, injuries to the birth passages, and the general medical and surgical complications of labor. Section 5 is devoted to obstetric operations—the therapeutic induction of abortions, the inductions of labor, forceps, version, cesarean section, mutilating operations, and a section on the operations for diverse obstetric complications. The sixth section discusses the complications of the puerperium. Five chapters are devoted to this subject. In the seventh section the newborn infant is discussed, including birth injuries and treatment of asphyxia in the newborn. The final section is a general discussion and includes a detailed presentation on the preparation for an obstetric operation, which is most valuable to the obstetrician. This is followed by a discussion of postpartum and postoperative care of the patient, obstetric analgesia and anesthesia, and lastly a section on intravenous transfusions.

The volume covers a comprehensive mass of material, but everything is presented so clearly and so systematically that the obstetrician will thrill at the opportunity to reach for this volume whenever he is confronted with something that is different from the routine to which he is accustomed. Your reviewer recommends that this new fourth edition be found on the shelf of every obstetrician who ever feels the urge to "look something up."

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BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Thoracic Surgery. By Richard H. Sweet, M.D., Associate Clinical Professor of Surgery, Harvard University Medical School. Illustrations by Jorge Rodriguez Arroyo, M.D., Assistant in Surgical Therapeutics, University of Mexico Medical School. Philadelphia: W. S. Saunders Company, 1950. Price, \$10.00.

Physiology and Anatomy. By Esther M. Greisheimer, B.S. in Education, M.A., Ph.D., M.D., Professor of Physiology, Temple University School of Medicine, Philadelphia; formerly Professor of Physiology, Woman's Medical College of Pennsylvania, Philadelphia; formerly Associate Professor of Physiology, University of Minnesota, Minneapolis. 478 illustrations, including 52 in color. Sixth edition. Philadelphia: J. B. Lippincott Company, 1950. Price, \$4.00.

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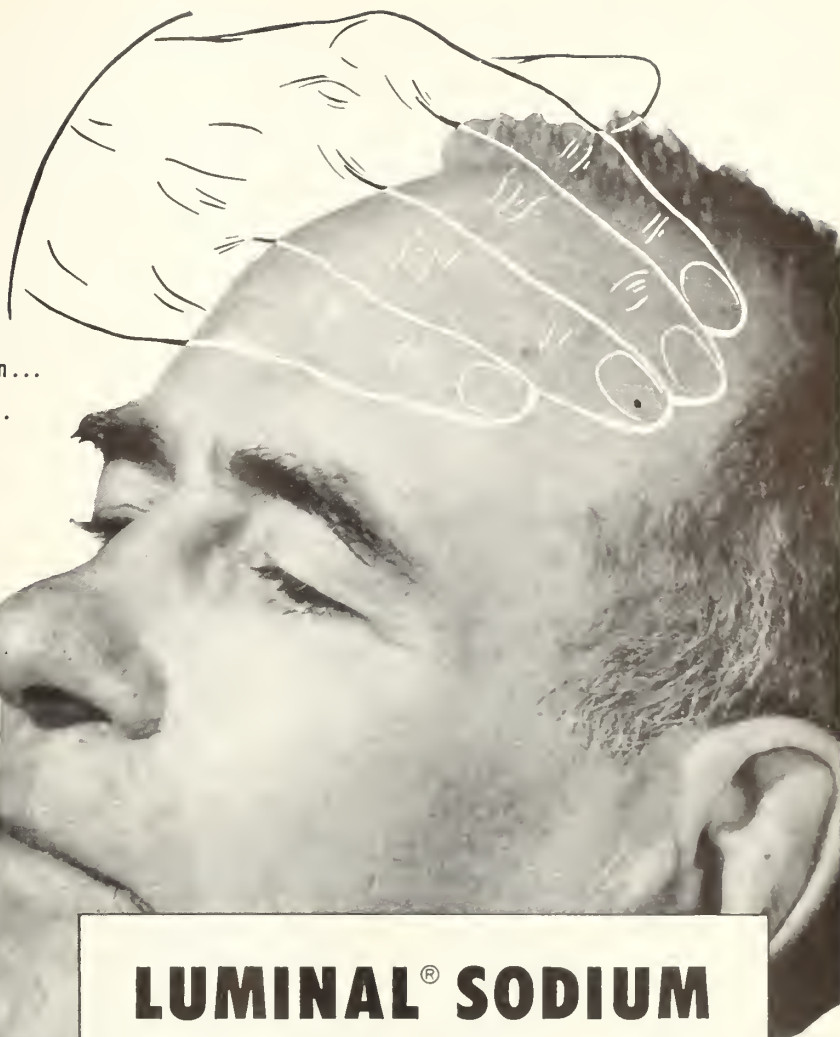
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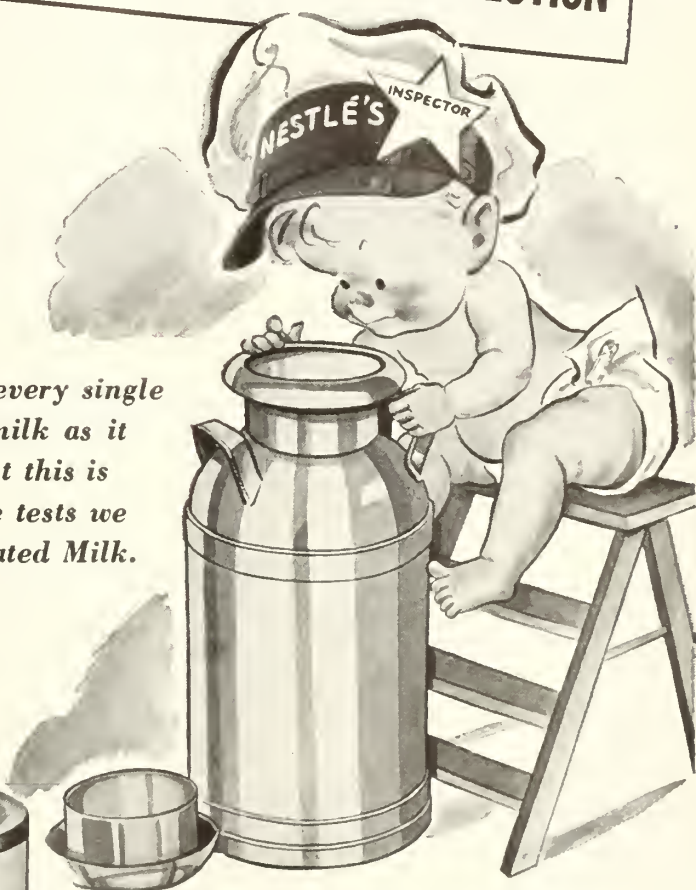
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DOCTORS EVERYWHERE KNOW NESTLÉ'S

AMA COUNCIL SETS STANDARDS FOR SUN LAMPS

The Council on Physical Medicine and Rehabilitation of the American Medical Association on October 20 announced its requirements for the performance and advertising of sun lamps in order to obtain the council's Seal of Acceptance.

"These requirements," it was explained by Howard A. Carter, secretary of the council, "are designed to protect the public against unwarranted claims of the curative and beneficial values of sun lamps."

Natural sunlight contains a band of wavelengths in the extreme ultraviolet, extending from about 2900 to 3200 angstroms, that is specific in preventing and curing rickets and also in producing vitamin D, reddish skin, and tan. With the exception of the tanning reaction, which extends to about 3700 angstroms, solar radiation of wavelengths longer than about 3200 angstroms has been found to be of no specific biologic action.

To comply with the requirements for minimum intensity, a sun lamp must generate sufficient ultraviolet energy to produce a minimum perceptible erythema (reddening of the skin) on the average untanned skin in not more than one hour at a minimum distance of two feet. If the intensity is less than this, the council is of the opinion that the radiation is too weak to have any significant prophylactic effect against rickets. An operating distance of two feet, it adds, is too short for use in a nursery.

"In accepting sun lamps, the council requires physical evidence of their production of energy from 2800 to 3200 angstroms in wavelengths at an intensity which is adequate and safe for use by laymen," said Mr. Carter.

"It has been demonstrated both clinically and experimentally that adequate ultraviolet energy between 2800 and 3200 angstroms plays an important role in deposition of calcium and may prevent rickets. There is no warrant for the claim, however, that ultraviolet rays will insure normal tooth structure or that ultraviolet rays will prevent dental caries."

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Another Unkind Cut

An Editorial

Poliomyelitis

Edith E. Nicholls

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*for rapid response
in the pneumonias*

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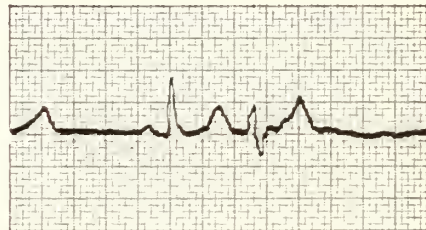
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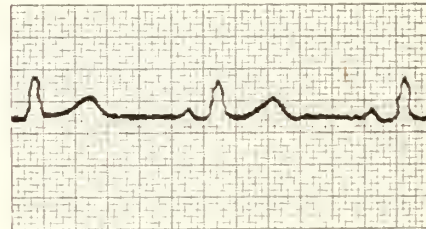
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treatment of ventricular arrhythmias*

Effect of a single oral dose of PRONESTYL
in ventricular premature contractions

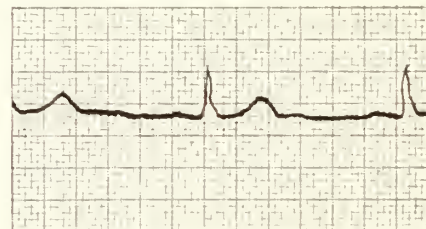
Lead II.
Control tracing:
normal sinus rhythm,
ventricular extrasystole.



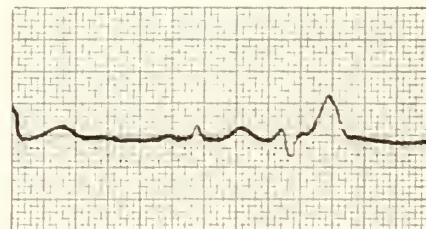
Lead II.
Tracing 30 minutes after
1 Gm. Pronestyl orally.
No ventricular premature
contractions present.



Lead II.
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later shows
persistent effect.



Lead II.
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shows return of
ventricular premature
contractions.



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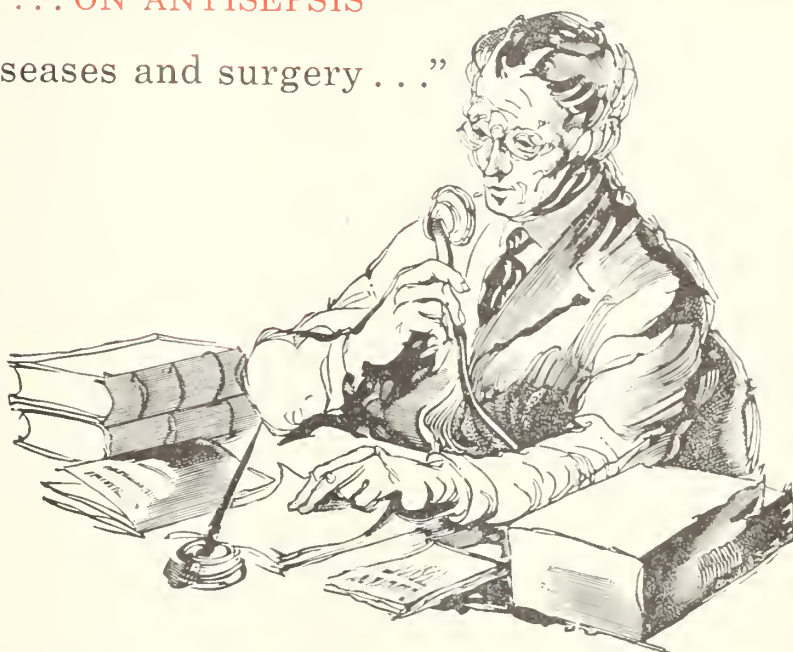
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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Case report abstracted from: King, E. Q. et al.: J.A.M.A. 143:1 (May 6) 1950.

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1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J.A.M.A. 143:1 (May 6) 1950.
2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.

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LETTERS

Study Clubs Endorsed

GENTLEMEN:

I am writing to heartily endorse the "study club" programs which were initiated at the 1950 State Society convention. I think this feature should be continued as a part of sectional meeting programs and advanced in the schedule. Coming as it did at the end of the program, it seemed to me that it was laboring under a disadvantage.

The obstetric-gynecologic section certainly received this with a great deal of enthusiasm, and the panel physicians deserve a rousing vote of thanks. They were asked a great many difficult questions, but came up with sound, reasonable, and conservative answers.

Differences of opinion from throughout the country were freely expressed or quoted, helping to make it one of the most educational portions of the week's program.

_____, M.D. (Pa.)

What's New in Industrial Health?

GENTLEMEN:

At a recent meeting of the Council on Industrial Health many important matters were considered. I would like to take this opportunity to review some of the highlights.

Civil defense assumed an important position on the agenda. The Committee on Industrial Medical Aspects of Civil Defense has been reactivated, but some reorganization is necessary in view of modifications in scope and objectives as cited below:

1. Effective use of industrial manpower including proper placement and health maintenance of the work force, especially substandard workers.
2. Recruitment and training of medical and allied professional personnel.
3. Integration of industrial medical services into the community civil defense program.
4. Training of industrial medical personnel in the nature and effects of modern weapons.

Planning is closely coordinated with the program of the Council on National Emergency Medical Service.

The joint committee containing representatives from the American Association of Industrial Physicians and Surgeons, the American Association of Industrial Nurses, and the Council on Industrial Health is making progress in preparing a statement of policy and practices for nurses in industry. Such a statement is intended to modify and clarify the council's published "Standing Orders for Nurses in Industry" as regards what constitutes adequate medical supervision. A thorough study of the medical and nursing practice acts has been made by the Bureau of Legal Medicine and Legislation as a basis for a statement of policy acceptable to all three groups.

At the invitation of the Professional Relations Committee, Dr. Arch Walls, chairman of the board, and Dr. Paul Davis, a board member of the American Academy

of General Practice, met with members of the council to explore the possibilities of furthering the development of industrial health education and service. As a result of this meeting, a joint committee of the two organizations is proposed for the purpose of extending general practitioners' participation on the basis of planned education.

Recently, several states have adopted laws intended to improve the status of first-aid facilities and services in industrial medical departments. The Council on Industrial Health, in response to a number of requests, is proceeding to develop an industrial first-aid manual with assistance from other agencies in the American Medical Association, and elsewhere. Attention will be given to suitable facilities and equipment, proper training, and over-all medical supervision.

The eleventh annual Congress on Industrial Health will be held on Feb. 26-27, 1951, at the Atlanta-Biltmore Hotel in Atlanta, Ga. Preceding the Congress, on Sunday afternoon, February 25, the chairmen of the state Committees on Industrial Health are invited to a joint meeting with our council. This will afford us an opportunity to get acquainted and to discuss many problems of common interest. Now is the time for each chairman or designated state representative to make arrangements with his state medical society officers for attending this important meeting.

J. F. McCahan, M.D., *Assistant Secretary*,
Council on Industrial Health,
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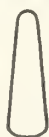
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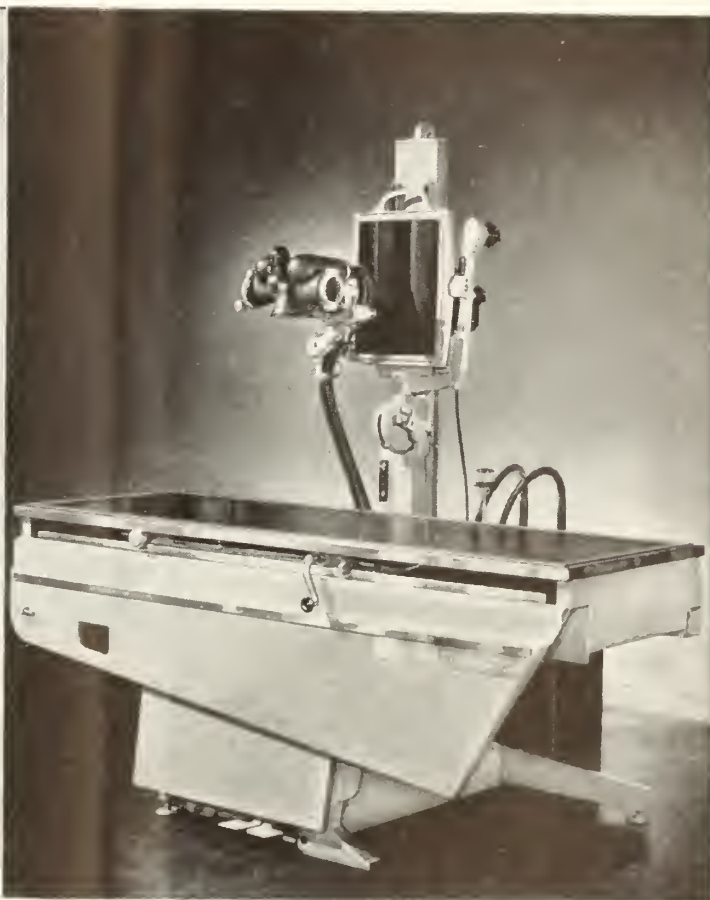
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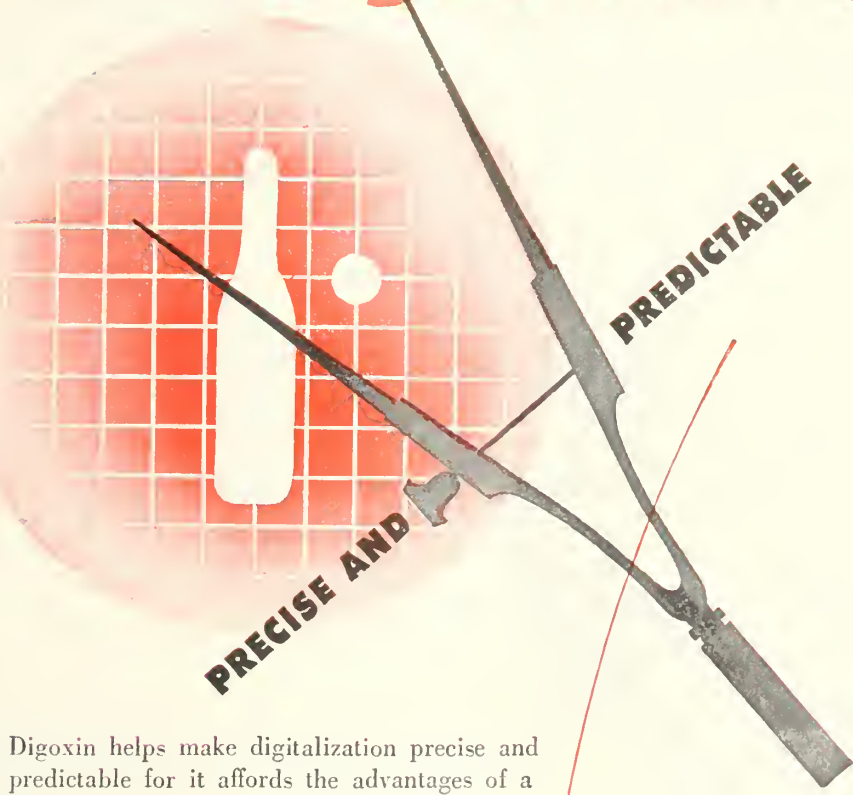
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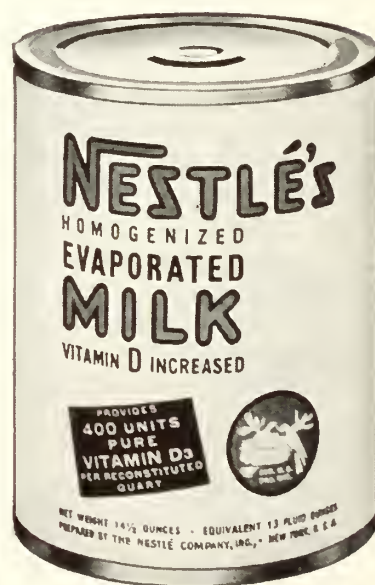
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The Present Status of Antibiotic and Chemotherapeutic Agents in Surgery

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EXPERIENCE has shown that the results obtained with the modern chemotherapeutic agents in surgical practice depend largely upon the clinician's observance of certain factors and principles. When used properly today, the antibacterial agents can produce a profound effect on the prevention and control of infections that may occur in surgery. When used improperly, their clinical effect may be limited, incomplete, or absent. This discussion is intended to review the importance of the various factors which control the effectiveness of chemotherapy and to indicate the beneficial uses and limitations of these agents at the present time.

Many surgeons have recently expressed a belief that there is no longer any problem in the prevention or control of infections since a wide selection of antimicrobial agents is now available. This belief is erroneous because many of the old problems still persist and new ones have arisen with the introduction of each new agent. As you will hear in the papers which follow, the prob-

lems in chemotherapy have been actually growing in complexity.

Early Diagnosis. The problem of early diagnosis is of considerable importance in determining the results obtained with chemotherapy in regard to morbidity, mortality, and functional results. If the diagnosis is established early, when pure or single bacterial infections are in the diffuse or cellulitic stage, chemotherapy is most apt to produce a prompt and rapid control of the invasiveness with complete and spontaneous resolution or a minimal amount of tissue destruction or other complications. On the other hand, if the diagnosis is made late, the effect of chemotherapy is more limited and delayed, and complications are more numerous. The infectious process has usually become more established, and either local necrosis and abscess formation have occurred or systemic invasion has developed. With late diagnosis, particularly in staphylococcal infections, the invasive qualities of the infection are generally overcome and the process is localized, but necrosis of tissue usually occurs. Frequently chemotherapy will so control the invasive qualities of certain infections that emergency, radical, surgical decompression, or excision of infected areas either becomes unnecessary or can be replaced by more conserva-

Read as part of the Symposium on Antibiotics and Chemotherapeutic Agents at the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 16, 1950.

From the Department of Surgery, College of Medicine of the University of Cincinnati, and the Cincinnati General Hospital.

TABLE I
COMPARISON OF GROUP BACTERIAL SENSITIVITY TO
PENICILLIN, CHLOROMYCETIN, AND AUREOMYCIN
in Vitro

Type of Bacteria	Micrograms of Antibiotic Per cc. Necessary for Bacterial Inhibition		
	Penicillin	Chloromycetin	Aureomycin
Hemolytic Staph.			
aureus	.03	1.0 - 5.0	.07- 10.0
Nonhemolytic			
Staph. aureus .	.05	2.5 - 5.0	.10- 2.0
Hemolytic			
streptococcus ..	.003	.75- 2.5	.25- 1.0
Nonhemolytic			
streptococcus ..	.03	1.5	.20- 2.5
Streptococcus			
viridans	.01	2.5	.20- 10
Pneumococcus ..	.03	1.0 - 2.5	.5 - 1.0
Gonococcus	.03	1.0 - 2.5	.25- 1.0
E. coli	50 -500	.50-12.5	1.0 - 25.0
A. aerogenes ...	100 -500	0.5	1.0 - 50.0
B. proteus group	50 -500	5.0 -10.0	2.0 -200.0
A. faecalis	.03-20.0	1.0 -50.0	2.0 - 50.0
Ps. aeruginosa .	200 -1000	10.0 -50.0	20.0 -250.0
E. typhosa	6.0	0.5	1.0 - 6.0
Cl. welchii	.05- 1.0	2.0 -50.0	1.0 - 50

active local types of surgery done at a time when the patient's condition is improved.

The presence of secondary or metastatic complications usually delays or prevents a complete response to chemotherapy. This is particularly true in those cases in which the infection has become disseminated with the production of metastatic abscesses or other infectious complications in remote areas. Failure to recognize the existence of metastatic complications and to treat them surgically usually produces incomplete chemotherapeutic response and prolonged morbidity or death. Failure of the elevated temperature and other general signs of infection to begin to recede within 72 hours of the start of chemotherapy generally implies the coexistence of a neighboring abscess or one or more complicating metastatic infections such as intraperitoneal abscess, embolic pneumonitis, meningitis, pericarditis, and thrombophlebitis.

Accurate and Complete Diagnosis. In many infections it is becoming increasingly important to have an accurate diagnosis not only as to the clinical lesion but also as to the etiologic agent or agents. The necessity of a correct clinical diagnosis and evaluation of the patient's condition for intelligent therapy is obvious. However, the importance of obtaining information regard-

ing the infecting micro-organism is becoming more and more important. Immediate examination by smear and culture of exudate obtained by incision and drainage or aspiration with needle and syringe from the actual site of infection is recommended to help establish the clinical diagnosis and nature of the etiologic agent.

Selection of Proper Chemotherapeutic Agent. Results from study of the gram-stained smear of exudate obtained from the lesion will permit the selection of one or more agents which probably will be effective. This procedure is generally preferable to the blind selection of an antibacterial agent during the first few days of treatment. If no exudate can be obtained, or if no local lesion is demonstrable, the selection of the agent must be made on a presumptive diagnosis until the nature of the causative organism is determined. A study of Table I indicates the general group sensitivity of bacteria to penicillin, chloromycetin, and aureomycin *in vitro* and suggests the agents to be considered for selection.

In this regard it is important to realize that there is considerable variation in natural bacterial resistance within strains of micro-organisms. Consequently, the haphazard selection of an antibiotic agent, which presumably should be effective for a given etiologic agent, may yield an uncertain result or a failure.

However, our *in vitro* studies of various strains of bacteria within the same group or species revealed a marked variation in natural susceptibility and resistance to penicillin, aureomycin, chloromycetin, and terramycin. Table II shows the incidence of susceptibility of the various types of infecting bacteria exhibited at or before the start of treatment, the determinations being made by the gutter plate method, using 10 micrograms per cc. for penicillin and 50 micrograms for aureomycin, chloromycetin, and terramycin. In addition, the serial tube dilution method was used to test questionably susceptible strains.

While it is evident that many of the gram-negative and gram-positive species of pathogenic bacteria commonly associated with surgical infections are susceptible to these antibiotics, it is also evident that considerable variation in susceptibility occurs within each species and that appreciable percentages of many are resistant to as much as 50 micrograms per cc. This is particularly true of the proteus group in which the susceptibility of different strains varied from 0

per cent to 35 per cent for aureomycin and from 25 per cent to 100 per cent for chloromycetin. Of special importance was the fact that definite but varying percentages of all of the groups of bacteria commonly associated with surgical lesions were resistant to each of the three antibiotics, penicillin, chloromycetin, and aureomycin. Similar studies of the incidence of natural resistance within bacterial species have been made by Pulaski.

These observations emphasize the importance of doing bacterial susceptibility tests to the various chemotherapeutic agents as soon as possible in order to assure the proper selection of the agent and a beneficial effect. A wide variety of agents are now available for the treatment of gram-positive pyogenic infections, but selection, particularly in serious infections, should be based on sensitivity tests whenever possible. For pure gram-negative bacterial infections, these tests are even more important. Effective agents for *Ps. aeruginosa* and *B. proteus* infections are often not available.

In the treatment of mixed infections produced by a variety of gram-positive and gram-negative and aerobic and anaerobic bacteria, it is often advisable to select two or more antibacterial agents for treatment. In conditions such as acute septic peritonitis, intra-abdominal abscess, perinephric abscess, urinary tract infections, and various types of wound infections, two or occasionally three agents are necessary for complete antibacterial coverage. Usually penicillin and either aureomycin, chloromycetin, or terramycin are selected on the basis of sensitivity tests. Methods are available for completion of sensitivity tests

within 18 to 48 hours after isolation of the infecting agent. It is strongly recommended that clinicians have available in their local hospitals a laboratory capable of adopting this method of determining readily and quickly the antibacterial susceptibility of the infecting micro-organisms. Reports on relative susceptibility of bacteria are possible often before complete identification has been made. If these tests do not corroborate the earlier selection of the antibacterial drug, its administration is replaced by that of an effective one.

It is advisable to repeat the sensitivity tests at weekly intervals in severe or prolonged infections because of the possible acquisition of resistance to the chemotherapeutic agents by bacteria during therapy.

It is significant to note that acquired resistance was developed by some strains of bacteria during antibiotic therapy in our series of cases. Out of a total of 216 susceptible strains of bacteria sensitive to chloromycetin, 14, or 6.6 per cent, developed resistance, while 8 out of 88, or 9.9 per cent, strains acquired resistance to aureomycin. In the case of penicillin, 12 strains out of a total of 82, or 14.6 per cent, acquired resistance during therapy. Occasionally the suppression of sensitive bacteria in mixed infections by antibiotics may permit other bacteria normally of lesser virulence to become invasive and to invade the blood stream, meninges, or some other tissue. We have seen this occur on three occasions with gram-negative bacteria such as *B. proteus*.

These studies indicate that acquired bacterial resistance may develop under treatment with

TABLE II
PERCENTAGE OF SUSCEPTIBILITY OCCURRING WITHIN BACTERIAL SPECIES

Organisms	Penicillin Strains/Susc. %	Aureomycin Strains/Susc. %	Chloromycetin Strains/Susc. %	Terramycin Strains/Susc. %
<i>E. coli</i>	84/0	74/33.8	85/69.4	34/70.6
<i>Proteus</i> group	115/0	97/25.8	110/60	40/50
<i>A. aerogenes</i>	38/0	40/15	41/80.5	19/73.6
<i>Ps. aeruginosa</i>	50/0	48/6.3	56/23.0	27/25.9
<i>A. faecalis</i>	6/0	5/40	6/66.6	
Hem. <i>Staph. aureus</i>	68/48.5	53/67.9	76/86.9	29/89.7
Nonhem. <i>Staph. aureus</i>	70/41.4	60/46.6	73/69.9	17/70.6
Nonhem. <i>Staph. albus</i>	7/71.4	6/66.6	6/83.3	
Hem. <i>streptococcus</i>	23/73.9	18/66.6	20/85	5/100
Nonhem. <i>streptococcus</i>	42/30.9	33/39.4	42/78.6	10/80
<i>Streptococcus viridans</i>	6/83.3	6/66.6	5/100	2/100
Anaerobic <i>streptococcus</i>	8/50	4/0	6/50	
<i>Cl. welchii</i>	30/76.6	28/89.1	29/93.1	11/63.6

aureomycin and chloromycetin, but with less frequency than in previous studies with streptomycin. This also emphasizes the importance of using these agents intelligently in order to prevent therapeutic failures.

Adequate Dosage. Although the entire question of dosage in antibiotic therapy is in a state of flux, there is sufficient evidence to indicate that the dose of the agent should be sufficiently large to produce antibacterial effects in the blood and intercellular fluids, and that the duration of therapy should be sufficiently long to permit the natural defensive mechanisms of the body to dispose of the inhibited but often still virulent bacteria.

It is important to remember that the majority of agents exert only a bacteriostatic effect which is greatest on actively growing and reproducing bacteria. Failure to continue treatment sufficiently long to permit elimination of the bacteria by the body's defenses may result in an exacerbation of the infection.

In the case of some of the antibiotics and particularly penicillin, there is evidence that progressively large doses have an increasingly greater antibacterial effect. An example of this is the *in vivo* effect of progressive doses of penicillin in experimental gas gangrene produced by highly virulent *Cl. welchii*.

When a standard dose of 2000 units of penicillin per kilogram of weight per day was used in animals inoculated with one to one thousand minimum lethal doses of *Cl. welchii*, no measurable effect was evident and all the animals died within two and two-thirds days at a slightly faster rate than the controls. When the dose was increased four times to 8000 units per kilogram, a definite beneficial effect was detected, the rate of death being retarded and 16 per cent of the animals surviving at the end of four and two-thirds days. In the group of animals receiving 32,000 units per kilogram, or sixteen times the standard dose, the prophylactic value of penicillin became evident. The size and spread of the lesion were greatly diminished, and 64 per cent of the animals survived for the period of four and two-thirds days. An additional increase in the protective effect of penicillin was apparent when the dose was increased to 96,000 units per kilogram. The control of the rate of spread of the infection was obvious, the lesions being small and often insignificant compared with those in the controls. Ninety per cent of the animals

treated with this dose survived for four and two-thirds days even under the severe challenge of this type of infection.

These observations have been borne out in the management of clinical cases of gas gangrene. Aureomycin and chloromycetin in average dosage are as effective as penicillin in massive dosage in experimental gas gangrene.

Timed Surgical Intervention. A mistake commonly made today is the use of conservative therapy with chemotherapy and a prolonged delay in doing an indicated surgical procedure. Failure to incise and drain existing abscesses before, at, or shortly after the onset of chemotherapy may not only lull one into a sense of false security, because of the masking of symptoms, but also may permit the development of bacterial resistance in refractive infections.

Removal of infected necrotic tissue, sequestra, or foreign bodies is important for the same reasons. It is not justifiable in our opinion to treat a patient conservatively with a chemotherapeutic agent and to postpone surgery indefinitely when surgical treatment as an adjunct will produce a more prompt, safer, and more satisfactory result. In general, chemotherapy should not be relied upon alone in the treatment of infectious lesions which require for their correction surgical or other forms of treatment.

Untoward Reactions. Unfortunately, untoward reactions may develop during therapy with any of the chemotherapeutic agents, and it is advisable for the clinician to be alert for their occurrence. The untoward reactions attending the use of the sulfonamides, penicillin, and streptomycin are well established. Those occurring with the other newer agents are also well known now. The threat of nephrotoxicity has tended to limit the scope of usefulness and dosage of bacitracin and neomycin. The occurrence of vertigo, headaches, paresthesia, ataxia, and renal irritation in approximately one-half of the cases treated with full dosage of polymyxin has had a similar effect on curtailing the systemic use of this agent in those infections produced by bacteria resistant to other available antibiotics. If either bacitracin or polymyxin is used systemically, careful evaluation of the renal function before and during treatment is indicated.

The general toxicity of the newer agents aureomycin, chloromycetin, and terramycin is fortunately low. Pruritus, stomatitis, allergic skin reactions, and the Herxheimer type of fe-

brile reaction have been occasionally noted with aureomycin. Maculopapular cutaneous rash appearing on the fourth to seventh day and stomatitis on the fifth to eighth day have also been occasionally seen with chloromycetin. Our experience has been more limited with terramycin, but to date we have seen paresthesia and headache develop in one case and an allergic cutaneous rash during therapy in another.

Unfortunately, however, signs of gastro-intestinal irritation such as nausea, vomiting, and diarrhea may occur during treatment with either of these drugs and may make the patient very uncomfortable. This is particularly true with aureomycin and terramycin, but much less so with chloromycetin.

Toxic reactions and idiosyncrasies to the various antibacterial agents present some of the new and additional problems in the control of surgical infections.

Supportive Therapy. Obvious derangements in local and general physiology are frequently overlooked or disregarded in present-day chemotherapy of established infections. Time does not permit a discussion of these alterations, but if they are not corrected, the full therapeutic effect of the antibacterial agent will not be obtained.

Prophylaxis with Chemotherapeutic Agents. The prophylactic use of antibacterial agents at

the present time is of benefit in the treatment of contaminated wounds of violence, in elective surgical procedures performed through or in contaminated areas, in injuries or operations of the oral cavity in patients with pre-existing valvular heart disease, and in temporary urinary tract derangements. The routine use of antibiotic therapy after elective surgical procedures in clean operative fields is not indicated.

Summary

As a result of numerous advances in the field of antimicrobial therapy during the past 15 years, the outlook of surgical patients with established infectious lesions or operations performed in contaminated fields has become vastly improved. Many of the infections commonly seen in surgical practice can now be controlled very effectively in conjunction with timed surgical intervention when indicated. However, there are still many surgical lesions of microbial etiology which are refractive to any known form of chemotherapy. The management of individual cases with infections has not been necessarily simplified from the surgeon's standpoint because of the continued existence of many of the old problems as well as a large number of new ones which have followed the introduction of the newer antibiotic agents.

A FORWARD-LOOKING PROGRAM

The University of Pittsburgh has announced its new program in the field of psychiatry, in part, as follows:

"Dean McElroy of the School of Medicine has been persistent in keynoting this major problem in medicine and Governor Duff displayed foresight in early asking the university to take over the Western State Psychiatric Institute and Clinic.

"The program as planned will engage the services with the university of:

Dr. Henry W. Brosin, professor of psychiatry and head of the division of psychiatry at the University of Chicago Medical School.

Dr. Benjamin Spock, distinguished authority on child development and preventive mental hygiene at the Mayo Clinic and the University of Minnesota.

Dr. I. Arthur Mirsky, associate professor of experimental medicine in psychiatry at the University of Cincinnati's School of Medicine and director of the May Institute at Cincinnati.

"The program and appointment of Drs. Brosin, Spock, and Mirsky were made possible by a working agreement between the university and the Commonwealth of Pennsylvania and the Maurice and Laura

Falk Foundation. It is expected that the program will cost approximately \$1,650,000 a year. Through this program will ultimately be achieved the purpose for which the Psychiatric Institute was built by the State.

"Other schools and departments in the university which will participate are the School of Nursing, the Graduate School of Public Health, the Department of Psychology, the School of Social Work, and public agencies such as the City Health Department and the public schools, also the Child Guidance Center, the Children's Hospital, the new Neuropsychiatric Veterans Hospital now under construction at Leech Farms, and the Allegheny County Juvenile Court."

In discussing the new program, Dr. William S. McElroy, dean of the School of Medicine, said: "If the incidence of mental illness is to be reduced and prevented, it is necessary that greater emphasis be placed upon teaching and research and the more intimate integration of psychiatry with all fields of medicine. The proposed program was planned to accomplish this objective. The addition of this psychiatric team to the Medical Center adds a critically important unit to a medical center that serves all of western Pennsylvania as well as the city of Pittsburgh. It has been made possible by the wholehearted support of the local members of the medical profession engaged in the field of psychiatry."

Aureomycin, Chloramphenicol, and Terramycin

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AUREOMYCIN, chloramphenicol, and terramycin will be considered together, since they possess many features in common, namely, their broad spectrum of therapeutic effectiveness, their low toxicity, and their relatively good absorption from the gastro-intestinal tract which makes oral administration practical. These newer antibiotics are effective against both gram-negative and gram-positive bacteria, certain viruses, and rickettsial infections. In contrast to penicillin, these newer agents produce beneficial clinical results in such diseases as primary atypical pneumonia, lymphogranuloma venereum, granuloma venereum, rickettsial diseases, amebiasis, and brucellosis.

For the most part, these newer antibiotics are relatively non-toxic, although the gastro-intestinal distress which is seen most often following aureomycin is often troublesome and at times necessitates discontinuing the drug. The employment of antacids and aluminum hydroxide preparations in alleviating the gastro-intestinal toxicity has been shown to lower appreciably the plasma concentration of aureomycin and it is probable that for optimal absorption, neither antacids nor food should be taken at the same time as the drug. In addition, mucous membrane involvement of the mouth, tongue, vagina, and anus is at times observed. Isolated cases of dermatitis, agranulocytosis, and other toxic reactions have been attributed to these newer antibiotics. Caution must be exercised when these agents are administered over a long period of time because of the change in the bacterial flora of the intestinal tract.

All three agents give rise to therapeutic levels in the blood stream for twelve hours or more following a single oral dose of one gram. Aureomycin is also administered intravenously, which is an advantage in patients unable to take oral medication. In this connection, caution should be exercised against large doses (over

200 mg.) at one time, and it should not be given too fast because of resulting vomiting, chills, and convulsions. Chloramphenicol can be given by rectum, although the concentration of the drug in the circulating blood varies greatly. From a pharmacologic standpoint, these newer antibiotics diffuse well into the spinal fluid, pleural cavity, and biliary system.

In general, the total daily oral dosage for all three drugs is 2 to 4 Gm. in divided doses at six-hour intervals, with an initial loading dose of 500 mg. for seriously ill patients. In contrast to penicillin and streptomycin, the action of these new antibiotics is primarily bacteriostatic rather than bactericidal; hence, the necessity of continuing these drugs for a longer period of time than in the case of penicillin and streptomycin. Also, for this reason, there is a lack of therapeutic effect in certain infections, such as subacute bacterial endocarditis, with aureomycin, chloramphenicol, and terramycin.

Combined Therapy. Not infrequently, one is faced with the problem of whether to employ one or more antibiotics at the same time. This question of combined therapy remains an extremely important but yet largely unexplored field of chemotherapy. As yet there are relatively few clinical conditions in which two therapeutic agents, such as a combination of antibiotics with one another, or with other agents, such as the sulfonamides, have been clearly proved to be more effective than one alone. Nevertheless, there are certain conditions in which the effectiveness of combined therapy has been demonstrated, such as penicillin and streptomycin in enterococcus infections and streptomycin and aureomycin in the treatment of brucellosis. On the other hand, a potential disadvantage of combined therapy concerns the possibility that antibiotics when administered together may actually interfere with each other in their action. It has been shown in the laboratory that the action of penicillin can be retarded by the use of chloramphenicol. The explanation for these observations may lie in the fact that penicillin has been shown

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to kill only those organisms which are in the process of multiplication. If another agent, such as chloramphenicol, renders them static, they are no longer killed by penicillin. Hence, it is not advisable to use more than one antibiotic at the same time, unless there is a definite indication for the same; in other words, purposeful therapy rather than hopefulness in therapy.

Drug Resistance. We encounter acquired drug resistance particularly with streptomycin in the treatment of acid-fast and certain gram-negative infections. With streptomycin, this resistance develops quite rapidly, whereas with aureomycin, chloramphenicol, and terramycin the resistance develops much more slowly. In this connection, it is to be remembered that the use of the antibiotics, especially over a long period of time, may result in a shift of the bacterial flora so that an organism may flourish in the presence of these drugs. Thus, an unusually occurring non-pathogen, such as *Proteus vulgaris*, may produce a severe infection of the meninges. Hence, in a disease such as meningitis, it is important to consider the possibility of the development of a super-infection, as additional therapy is required in such instances.

Proper Selection of Antibiotic. Unfortunately, the wide therapeutic range of the antibiotics has resulted in a failure to do careful bacteriologic studies in most instances. Usually these are reserved for cases failing to respond to therapy. For this reason, accurate figures dealing with the treatment of large groups of infections are becoming increasingly difficult to assemble and, as a consequence, data dealing with the newer forms of therapy are limited. Despite the broad action of these newer antibiotics, certain patterns have developed which demonstrate the fact that certain groups of bacteria are more easily controlled by different antibiotics. For example, certain strains of Friedländer's are more sensitive to aureomycin than to streptomycin. Many strains of staphylococci are resistant to penicillin, but will respond to aureomycin and chloramphenicol. Typhoid infections are best treated with chloramphenicol. Furthermore, most meningococcal infections are sensitive to penicillin, but it seems that equally good results are obtained with sulfonamides, as an occasional meningococcal infection will be resistant to penicillin. Not infrequently a unique situation exists wherein an antibiotic with a limited range of activity is the best drug for a given infection, such as polymyxin in the treatment of *pseudomonas meningitis*. In

other words, successful antibiotic therapy is becoming a more specific form of treatment and dependent to a certain degree on specificity of action—hence the importance of knowing the causative agent in each infection in order that the most suitable antibiotic can be administered.

Theoretically, this should be done routinely, but from a practical standpoint it is difficult to carry out. Obviously, there are many infections which respond dramatically to the antibiotics with no definite bacteriologic diagnosis. Therefore, there must be some middle road between the practice of giving antibiotics to everyone with an elevation in temperature and that of withholding antibiotic therapy until a definite diagnosis is established. Certainly all serious infections, such as those involving the blood stream, the meninges, and the endocardium, and those infections which fail to respond satisfactorily, demand efforts on our part to establish an etiologic diagnosis. Once the organism has been isolated, it is important that proper sensitivity studies be carried out. In evaluating these sensitivity studies, one must take into consideration not only the organism under treatment but also the ability of the drug to reach the area of infection in adequate concentration.

Streptomycin is most strikingly effective against the tubercle bacillus and against gram-negative bacilli. Because of its unique place in the treatment of tuberculosis, we feel that streptomycin should be reserved for this use, except in those instances where it is used in infections resistant to other antibiotics or in combination with other antibiotics. At this time penicillin shows its greatest effectiveness against infections due to gram-positive cocci, treponemal infections, and certain neisserian infections, such as the gonococcus.

Because of the broad range of therapeutic activity observed with aureomycin, chloramphenicol, and terramycin and of the extreme difficulty often encountered in differentiating bacterial and viral infections, there is a growing tendency to employ the newer antibiotics as the initial treatment in all infections. Despite this, penicillin by virtue of its bactericidal action remains the most effective drug against the majority of bacterial infections and, since it is least toxic, it remains the drug of choice in the initial treatment of most of the diseases encountered in this part of the world. If penicillin proves ineffective, then one of the newer drugs may be employed, depending on the clinical course and bacteriologic findings in each case.

THE CLINICAL USE OF NEOMYCIN

A Preliminary Report

JOHN R. WOLGAMOT, M.D., and GARFIELD G. DUNCAN, M.D.
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NEOMYCIN, an antibiotic produced by *Streptomyces fradiae*, was discovered by Waksman and Lechevalier in 1949 as a result of their search for an agent that would be active against streptomycin-resistant bacteria, particularly the tubercle bacillus. It is a basic compound, most active in an alkaline medium, thermostable, and readily soluble in water.¹

Neomycin is effective *in vitro* against a wide variety of gram-negative and gram-positive organisms, including *Mycobacterium tuberculosis*. Moreover, streptomycin-sensitive and streptomycin-resistant strains of a given bacterium are equally susceptible to neomycin.^{1, 2, 3, 4, 5, 6, 7} Investigations with experimental tuberculosis in animals have demonstrated that neomycin is highly effective in such infections, although apparently somewhat less so than streptomycin.^{3, 8}

Acquired bacterial resistance to neomycin has not been reported clinically, but this phenomenon has been produced experimentally. Under such circumstances the resistance pattern of neomycin conforms most closely to the step-like pattern characteristic of penicillin.^{6, 9, 10}

To date, only meager information has become available concerning the clinical use of this drug. In a recent report from Cook County Hospital, Felsenfeld and his co-workers have described 20 cases of tuberculosis, including streptomycin-resistant forms, treated with neomycin.¹¹ They concluded that it was an effective drug in extrapulmonary tuberculosis, but proved "less favorable in advanced pulmonary forms and without effect in tuberculous meningitis." No evidences of toxicity were observed.

Pertinent data from previous publications by

Duncan and his associates have been incorporated in the present report.^{12, 13}

The most extensive experience has been recorded by Waisbren and Spink at the University

TABLE I
CLINICAL RESPONSE TO NEOMYCIN THERAPY IN 43
PATIENTS WITH NON-TUBERCULOUS BACTERIAL
INFECTIONS. TWO DOUBLE DIAGNOSES
ARE INCLUDED

Diagnosis	Result			Total
	Cure	Improved	Failure	
Lower urinary tract infection	16	3	0	19
Pyelonephritis	7	2	3*	12
Mixed bacterial pneumonia	1	2	0	3
Friedländer's pneumonia	1	0	1*	2
Bronchiectasis	0	0	2	2
Staphylococcal septicemia	0	0	1	1
Peritonitis	1	0	0	1
Pyoderma	0	1	0	1
Retro-orbital abscess	0	1	0	1
Pemphigus (?)	0	0	1	1
Suppurative sinusitis	0	1†	0	1
Amputation stump infection	0	1†	0	1
Total	26	11	8	45

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From the Division of Medicine, Pennsylvania Hospital, Philadelphia, Pa.

* Duration of treatment was 24 hours or less in one patient in each of these categories.

† Topical therapy.

of Minnesota.¹⁴ These authors have recently published a detailed account of their use of neomycin in the treatment of 63 cases of infectious disease, including tuberculosis. Infections due to a wide range of gram-negative bacilli were favorably affected, including several instances in which all other available antibiotics had failed. Seven cases of tuberculosis were treated without evidence of favorable response. Ototoxic effects were encountered in 5 patients, and 7 revealed a

significant elevation of the blood urea nitrogen while under treatment.

The clinical applications of neomycin have been under study at the Pennsylvania Hospital during the past year, in cooperation with Dr. Selman A. Waksman and the Rutgers Research Foundation. To date, we have used this drug in 50 patients with a variety of infectious disorders, including 7 cases of tuberculosis.

Neomycin sulfate and neomycin hydrochloride were employed interchangeably, the potency of these preparations ranging from 139 to 200 units/mg. Twenty-six males and twenty-four females, between two months and 82 years of age, constitute the group herein reported. At the outset, neomycin was employed only when the offending organism was insensitive, by clinical trial and/or laboratory test, to all other antibiotics. With increasing experience we have employed it as the initial therapeutic agent in those instances where so indicated by bacterial sensitivity determinations.

The clinical results in 43 patients with non-tuberculous bacterial infections appear in Table I. In this category the term "cure" implies complete remission of symptoms and abnormal physical and laboratory findings, as well as cultural evidence that the causative organism has been permanently eradicated. The term "improved" applies to instances in which neomycin therapy was followed by partial remission of symptoms and eradication of one or more of multiple causative organisms. The average duration of therapy in this group of infections was six days. Early in this study doses up to 400,000 units daily were employed routinely. With increasing experience, the customary daily dosage has been serially decreased to 2000 units per kilogram of body weight without impairment of therapeutic efficacy. Larger doses are still employed, however, in the presence of a highly resistant pathogen or when the initial dosage proves inadequate for control of symptoms due to a presumably amenable bacterial infection. Inasmuch as the neomycin currently available varies considerably in potency, designation by units rather than grams is considered preferable.

Table II depicts this same group of non-tuberculous infections in terms of bacteriologic response to neomycin therapy. The term "cure" in this category applies only when the infectious organism has disappeared culturally during treatment and has remained absent during the period of follow-up study.

TABLE II
BACTERIOLOGIC RESPONSE TO NEOMYCIN THERAPY IN 43
PATIENTS WITH NON-TUBERCULOUS INFECTIONS.
MULTIPLE PATHOGENS WERE PRESENT
IN 13 CASES

Organism	Result		Total
	Cure	Failure	
<i>Gram-negative bacteria</i>			
Aerobacter aerogenes .	18	1	19
Pseudomonas (B. pyocyaneus) ...	1	7	8
Coliform bacilli	7	0	7
Escherichia coli	6	0	6
Proteus	3	0	3
Paracolon bacilli	2	1	3
Friedländer's bacillus .	2	0	2
Alcaligenes faecalis ...	1	0	1
Neisseria flava	0	1	1
Hemophilus influenzae	0	1	1
<i>Gram-positive bacteria</i>			
Streptococci	1	3	4
Diphtheroid bacilli ...	3	0	3
Micrococci	2	1	3
Staphylococcus aureus	0	2	2
Pneumococci	0	1	1
<i>Fungus</i>			
Geotrichum	1	0	1
<i>Yeast</i>			
Candida albicans	0	1	1
Total	47	19	66

Of importance is the fact that, following cure with neomycin, no instance of bacteriologic relapse occurred. This is in contrast with certain other chemotherapeutic agents in current use in which transient bacterial suppression, without definitive cure, is a not infrequent experience. The probable explanation of this feature is the very small difference between bacteriostatic and

bactericidal concentrations of neomycin for a given organism.

Details concerning 7 cases of tuberculosis treated with neomycin are depicted in Table III. With the dosage employed, convincing bacteriologic or clinical evidence of improvement due to neomycin was not encountered in any instance. Trial in a greater number of cases, employing

TABLE III
SUMMARY OF PERTINENT DATA IN 7 CASES OF TUBERCULOSIS TREATED WITH NEOMYCIN

Age	Sex	Diagnosis and Duration	Previous Treatment	Neomycin		Outcome
				Daily Dose	Days Treated	
54 yr.	F	Renal tuberculosis 13 years; ureteral stricture; uremia	Nephrectomy Streptomycin	91,000 units	17	Clinically improved following ureteral drainage. Post-treatment urine culture positive for tubercle bacilli
48 yr.	M	Renal tuberculosis 12 years; uremia	Streptomycin	120,000 units	3	Death due to renal insufficiency. Postmortem cultures positive for tubercle bacilli
25 yr.	F	Tuberculous adenitis 1 year; Pott's abscess	Streptomycin	96,000 units	46	Clinically not improved. Post-treatment lymph node biopsy histologically identical with pre-treatment biopsy; no microscopic evidence of healing. Post-treatment lymph node culture positive for tubercle bacilli
27 yr.	F	Renal tuberculosis 1 year; bilateral ureteral stricture with hydronephrosis; early uremia	Streptomycin P.A.S. Tibione	100,000 units	13	Death due to tuberculous meningitis of 2 weeks' proven duration. Pre- and post-mortem spinal fluid cultures positive for tubercle bacilli
61 yr.	F	Bilateral pulmonary tuberculosis with cavitation 4 months; diabetes; hypertensive cardiovascular disease	None	128,000 units	12	No improvement prior to death, clinically due to cerebrovascular accident. Autopsy not performed
20 yr.	F	Renal tuberculosis 1 year; Pott's abscess	Streptomycin Dihydrostreptomycin	132,000 units	33	Clinically not improved. Post-treatment urine culture positive for tubercle bacilli
24 yr.	F	Miliary tuberculosis 6 months; tuberculous meningitis 1 month	Streptomycin (73 Gm.)	80,000 units In combination with streptomycin 1 Gm. daily intramuscularly and 25 mg. on alternate days intrathecally	70	Still under observation. Totally deaf. Clinically quiescent, but grossly abnormal cerebrospinal fluid sugar, protein, and cell count persist

larger doses of neomycin, is contemplated. Dual streptomycin-neomycin therapy offers the theoretic advantage of destroying streptomycin-resistant variants as they occur, and this avenue will also be explored.

Parenterally administered neomycin was found to be rapidly absorbed. On a dosage of 500 units per kilogram of body weight every six hours, neomycin levels of 128 to 205 units/ml. of urine and 4 to 8 units/ml. of serum were attained within 24 to 48 hours and were relatively evenly maintained thereafter. Upon discontinuance of the drug, measurable serum levels persist up to 24 hours and urinary excretion continues for 24 to 48 hours.

Table V summarizes the type and incidence of toxicity encountered in this series. Because of our initial lack of knowledge as to the toxic potentialities of neomycin, 25 patients were studied pre- and post-therapeutically by determinations of bromsulphalein retention, electrocardiogram, and hemogram including bone marrow aspiration. In no instance did any of these studies reveal significant changes following therapeutic administration of neomycin. In addition to the foregoing, urinalysis, blood urea nitrogen determination, and audiogram prior to, during, and following treatment were included in the routine toxicity detection studies. These latter studies,

at regular intervals, are still considered a necessary corollary to clinical therapy with neomycin.

The nephrotoxic and ototoxic effects appear to be closely related. Of the 5 cases of impaired hearing, two occurred in patients with severe intrinsic renal disease. The remainder appeared in patients with preceding partial hearing impairment due to streptomycin. Relative to auditory function, the untoward effects of neomycin and streptomycin appear to be additive. In our experience the toxic effects of neomycin on the eighth nerve have been purely auditory, no instance of disturbed vestibular function having been observed.

Of the 5 patients who revealed significant rises in the blood urea nitrogen during treatment, three had an abnormal blood urea nitrogen and other evidence of intrinsic renal disease prior to therapy. The maximum serum neomycin levels in this group far exceeded those of non-toxic patients receiving comparable dosages of the drug. This inability to excrete neomycin normally is believed to represent an important etiologic factor in the causation of auditory damage. Whether the toxic factor, or factors, are intrinsic to the drug, or simply represent an impurity incident to manufacture, has not been established.

Thirteen patients ultimately died of their primary or intercurrent diseases, a reflection of the advanced years and frequently debilitated condition of the group studied. The time interval between completion of neomycin therapy and death ranged up to five months. Seven of these patients were subjected to autopsy examination, and in none were any gross or microscopic lesions attributable to neomycin noted. Specifically, no renal tubular lesions of the type encountered in animal toxicity studies were observed.⁸ In no instance was death attributed, directly or indirectly, to neomycin.

Summary and Conclusions

A clinical investigation of neomycin therapy in 50 cases of bacterial infection has been reported. It is active against certain gram-positive bacteria, but more so against gram negative organisms. It is highly effective in the curative treatment of genito-urinary infections, but is also applicable to a variety of other systemic and/or localized infections disorders. In the dosage employed, neomycin was without apparent benefit in 7 cases of tuberculosis. Nephrotoxic and ototoxic effects were observed, but in the absence of

TABLE IV
INCIDENCE OF TOXIC MANIFESTATIONS IN 50 PATIENTS
TREATED WITH NEOMYCIN. THE FOLLOWING LISTED
SIGNS AND SYMPTOMS WERE CONFINED TO
11 PATIENTS

	No. of Cases
Decreased auditory acuity	5*
Disturbance of vestibular function	0
Increased blood urea nitrogen	5†
Albuminuria (or increased albuminuria)	0
Hematuria	0
Fever	1
Arthralgia	1
Gastro-intestinal symptoms	1
Allergic reactions	0
Undue pain at site of injection	0

* Preceding partial hearing loss in 3 cases due to streptomycin.
† Blood urea nitrogen elevated prior to treatment in 3 cases due to intrinsic renal disease.

intrinsic renal disease or previous prolonged streptomycin therapy, these have been infrequent. Neomycin appears sufficiently unique and sufficiently safe to warrant wider, *supervised* clinical use.

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THE COCKROACH ROLE IN FOOD POISONING

The common cockroach has long been looked on with suspicion as a carrier of pathogenic organisms, especially those of the intestinal group. They seem by nature ideally suited for this purpose. Their flat bodies enable them to gain entrance to almost any kind of food container. Their insatiable appetites cause them to overeat and, when overdistended, they readily regurgitate their food. Thus they may contaminate food by vomitus, feces, and body contact.

Workers in the School of Public Health of the University of Minnesota (Theodore A. Olson and Myrtle E. Rueger, Experimental Transmission of Salmonella Oranienburg Through Cockroaches, *Public Health Reports*, 65: 531, 1950) have conducted an elaborate experiment to determine if cockroaches can carry infectious bacteria in their intestinal tract. They used four varieties of cockroaches, and the Salmonella oranienburg as the test organism. The problem is not as simple as it sounds. It took them five years to learn how to raise the cockroaches in the laboratory and the best means of anesthetizing them and of tying them up to prevent them from contaminating their wings and legs. If the body of a cockroach became contaminated, the organism remained viable for 78 days in ordinary atmospheric conditions. They were able to prove that after an infected feeding the fecal pellet contained the organism for 10 to 20 days, and even after the organism disappeared from the feces they could be demonstrated in the intestinal tract. The Salmonella oranienburg will survive in such excrement for 199 days at a relative humid-

ity of 31 per cent and 85 days at 52 to 56 per cent. It can survive on glass surfaces for 34 days, on corn flakes at least 62 days, and on crackers at least 88 days.

The authors point out, however, that "until the actual incidence of infection in wild cockroaches is determined on the basis of a large number of specimens and for a large number of geographical areas, and until this information is integrated with definite epidemiologic evidence, the roach can be regarded only with grave suspicion."—*Virginia Medical Monthly*, December, 1950.

CORTISONE AND ACTH FOUND HELPFUL IN TREATING SERIOUS SKIN DISEASE

Good results are reported by a group of doctors at Mount Sinai Hospital in New York who have used cortisone and ACTH to treat patients critically ill with acute disseminated lupus erythematosus.

Writing in the October issue of *Archives of Internal Medicine*, published by the American Medical Association, Drs. Louis J. Soffer, Marvin F. Levitt, and George Baehr caution, however, that "although these agents are capable of inducing clinical remissions they do not effect a cure of the underlying disease process."

Of the 14 patients treated with the hormones, 11 responded to the extent that the acute evidence of the disease promptly subsided and the patient could move about more comfortably. However, the diseased cells, the anemia, the abnormal kidney findings, and other characteristics of the disease persisted.

INFECTIONS OF THE HAND

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INJURIES and infections of the hand are rarely fatal. They produce such marked disabilities, however, and are, therefore, of so much economic importance that they should assume a major place in medical therapy. Infections of the hand are usually considered to be of such minor importance that they do not demand specialist therapy and it is quite true that they can easily enough be taken care of successfully in office practice if a careful diagnosis is made and early treatment is instituted. If infection progresses, more is demanded than can be obtained in the usual doctor's office. Because of the serious complications that may ensue from such infections, hospital therapy, with the facilities of the hospital operating room and postoperative care, is necessary.

The usual infecting organisms in hand and finger infections are the staphylococcus and the streptococcus. The greatest advance in therapy of infections of the hand and finger has come since the advent of penicillin, aureomycin, terramycin, and sulfa drugs. Most of the organisms are usually susceptible to the action of these antibiotics given systemically. Hence the early and rapid control of these infections can be brought about by the administration of these drugs in adequate dosage. In infections treated early it may be possible to abort the infection and avoid the necessity of surgery. However, when the infection has progressed to the necrosis of tissue and the formation of pus, conservative treatment with the antibiotics and sulfa drugs cannot be expected to combat the infection successfully. Incision and drainage are necessary to bring about a subsidence of the infection and healing. In infections of the hand and finger, necrosis is produced due to the shutting off of the blood supply by the pressure of the inflammatory reaction. Hence any hand or finger infection that has progressed for three or four days

without treatment almost invariably has to be treated by an incision and drainage.

There are certainly other principles of the treatment of inflammation which must be recognized and followed in spite of the fact that we have antibiotic therapy available; these include splinting, elevation of the part to reduce swelling and promote venous and lymphatic drainage, and meticulous care in protecting the involved area from reinfection both during time of treatment and at the time of dressing.

The decision as to when and how to drain demands careful consideration in infections of the hand and finger. This is no problem when fluctuation can be demonstrated, but in many infections the area of pus formation is so small or is in an area made so tense by the inflammation that fluctuation cannot be determined easily. Here, experience and clinical judgment are of importance. In a general way, it may be said that an infection of the hand and finger untreated for more than four days can be expected to have produced necrosis and pus.

In making incisions for drainage, care must be taken that more disability is not produced by the incision than by the original infection. On the other hand, the incisions must be wide enough to provide adequate drainage if early healing and avoidance of disability are to be obtained.

Rarely, in our day, does a systemic infection arise from hand and finger infection. In earlier days it was not uncommon to see a spreading lymphangitis from a finger or hand infection with rapid involvement of the epitrochlear and axillary nodes. Such cases respond rapidly to the systemic administration of penicillin and within 24 to 48 hours most of them are well. The infection is usually a virulent streptococcus and protective measures such as splinting of the arm and hand and hot wet dressings should be used even though antibiotics are given. Frequently the primary site of infection may be insignificant and with appropriate antibiotic therapy no local therapy is necessary.

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Infections of the Dorsum of the Hand and Finger

As a general rule, infections of the dorsum of the hand and finger may be looked upon as troublesome, but rarely dangerous or disabling. There are three typical infections on the dorsum of the hand which will be considered.

Paronychia. This is an infection extending between the nail and the overlying eponychium which usually begins at the side of the base of the nail as a red, swollen, tender area. It is the easiest infection of the hand to treat if it is seen early, because drainage can be obtained without anesthesia by simply raising the eponychium from the nail with a small scalpel. Drainage of a drop or two of pus is usual, and hot wet dressings will permit healing.

If the infection progresses around the base of the nail, a subungual abscess is usually produced. Drainage of this abscess requires a bilateral incision of the eponychium and excision of the nail base.

Furuncle of the Dorsum of the Proximal Phalanx. Furuncles frequently occur on the dorsum of the proximal phalanx from organisms which enter the hair follicles of this area. In the dense skin of the dorsum of the finger there is considerable cellulitis which often extends to the dorsum of the hand and may produce a picture which may be alarming to the patient and the uninitiated doctor. If treated early by splinting the involved finger, using wet dressings, and giving adequate doses of penicillin, the infection usually subsides without the necessity of an incision. This is one of the few areas in which fluctuation can be demonstrated in the hand, and if found, a crucial incision for drainage should be made. These infections are rarely dangerous. They never tended to involve a tendon and are of little more consequence than furuncles elsewhere in the body.

Infection of the Dorsum of the Hand. There are no true fascial space infections on the dorsum of the hand. Infections which arise are usually the result of puncture wounds or infections from bites or abrasions which produce a rather marked cellulitis with marked swelling and edema. The whole process subsides rapidly with adequate antibiotic therapy, splinting, and hot wet dressings. There is rarely any disability produced due to involvement or necrosis of the extensor tendons.

Infection of the Palmar Surface of the Hand and Fingers

Infections of the palmar surface of the hand and fingers are more serious because they may produce much more marked disability than those of the dorsum. The streptococcus and the staphylococcus are the usual infecting organisms and in approximately half the cases there is a history of a definite cut or injury. Many of these may be minor, such as a pin prick or the prick of steel wool or a splinter. Nevertheless, it is important to obtain a history of injury in order that the site of primary infection may be definitely localized.

Distal Closed Space Infection (Felon)

Infections of the pulp space at the tip of the finger are much more common and fortunately much less serious than the more extensive infections of the tendon sheath and palmar spaces. The fingers most commonly involved are the thumb and index finger and the infection usually arises from minute perforations of the skin from accidental pin pricks, needle sticks, or other such minor injuries. In the typical case, the patient feels a tickling sensation in the finger tip within about 24 hours of the time of injury. Gradually, the finger tip becomes tight, and throbbing is noted which rapidly increases in intensity. It is often sufficient to keep the patient awake at night and is not relieved by the drugs that are commonly used for the relief of pain.

The acute pain that is produced in such infections is the result of the inflammatory swelling in a more or less closed fascial space. The finger pulp is contained in a very distinct fibrous capsule which extends from the nail to the phalanx at the epiphyseal line. The space is traversed by numerous fibrous trabeculations which extend from the undersurface of the skin to the bone, thus dividing the pulp into numerous small, fat-containing compartments. Pressure produced by the inflammatory process produces marked tension in this area, interfering with the circulation in the fine vascular radicals and leading to a rapid necrosis of the poorly resistant fatty tissue. As the process continues, there is extension along the fibrous tissue trabeculations to involve the periosteum of the distal phalanx, and eventually a secondary osteomyelitis by contiguity may occur. Because of the fact that the distal closed space ends at the epiphyseal line on the distal phalanx and the flexor tendon inserts on the epiphysis of that phalanx, there is rarely a

tendency for the pulp space infections to extend to become a tenosynovitis.

The earlier appropriate therapy can be given, the less disabling will the infection become. In the very early stages of tickling and tightness in the tip of the finger, adequate doses of penicillin may abort such an infection and it is good practice to observe the effect of such therapy for at least 12 to 24 hours. Usually we have employed 100,000 units of the aqueous solution of penicillin in addition to 300,000 of the crystalline procaine injected intramuscularly. If the process has been of more than four days' duration, suppuration has almost surely taken place.

In Bolton's series of 50 cases, an abscess was found in every case where pain had been present for four days or more. The local findings of tense, swollen, bluish-red discoloration of the finger tip in a patient who has been kept awake all night with throbbing pain are indications of the presence of an abscess. Examination of the finger tip with a probe or hemostat will disclose the area of most acute tenderness which, as a rule, overlies the area of the abscess. Often close inspection will disclose the site of the injury, and occasionally an intradermal abscess may overlie the site of the infection. An incision directly into the area of suppuration gives the best results. Excision of the skin overlying the intradermal abscess may disclose a small sinus leading into the area of infection identified by a drop of pus at the site. In such cases, direct incision into the area of the abscess is made with certainty. When the abscess cannot be definitely located in the finger pulp, it is wiser to make a larger incision to make sure that adequate drainage is obtained. In my experience, the hockey stick incision or the through and through drain has not proved to be successful. An incision extending down in front of the phalanx is recommended, turning back the finger pulp as a flap to expose the abscess.

This type of surgery is best done under general anesthesia and the use of a rubber band or rubber tube tourniquet at the base of the finger produces a bloodless field and permits more rapid and accurate surgery. The more radical fish-mouth type of incision produces relatively little postoperative disability. The disability and deformity of a felon are the result of the necrosis caused by the infection rather than by the incision. If the fish-mouth incision is made far enough posteriorly just in front of the phalanx,

relatively little anesthesia or paresthesia is to be expected.

Postoperative care consists of adequate penicillin administration, hot moist dressings to permit the escape of retained liquefying necrotic material, and splinting. The splint not only immobilizes but protects the incised and tender finger against injury. We have found that a splint, formed of a hairpin or of paper clips, enclosed in adhesive is easily borne and can be readily molded to the shape of the finger dressing. Healing takes place rapidly as soon as the infection is controlled and the necrotic tissue is liquefied and removed. Depending upon the amount of necrosis, the finger may be expected to heal in two to three weeks.

It is my belief that conservatism should be practiced in dealing with any infection that has extended to the bone. Infection of the bone in such cases is by contiguity and not by a blood-borne infection. Drainage of the abscess of the distal closed space usually permits, also, healing of the associated bony lesion. Only in late cases is it necessary to remove sequestra with a curet or rongeur.

Cellulitis of the palmar aspects of the middle and proximal phalanx is not uncommon. This results from an injury with secondary infection and produces a swelling of the subcutaneous tissues. It may be easily differentiated from a tenosynovitis, however, by the fact that the swelling does not uniformly involve the entire finger and the finger is not held in fixed flexion.

In early cases, these infections may be aborted by treatment with penicillin and splints. In later cases, the suppurative process must be incised, usually by an incision directly over the area of the abscess formation.

Collar Button Abscesses or Web Space Infections

Infections under calluses, frequently seen in the distal palm, may arise from cracks or abrasions which permit the entrance of organisms into the area underneath the cornified epithelial layer. The infection begins as an intradermal abscess and, because of the leather-like, unyielding epithelium of the surface, the abscess extends through the true skin into the web space between the fingers. This typical formation with an abscess between the layers of skin perforating the true skin and the second abscess in the deeper subcutaneous tissues gives the name collar-button abscess to this type of infection. The appear-

ance of the process is typical. There is a tender swelling in the web between the fingers, the adjacent fingers at the base may be somewhat swollen and tender, and at the extremes of flexion and extension, pain is produced by inducing tension in the area of the inflammation. Pressure over the area of the callus is extremely painful and the swelling may be found to extend to the dorsum of the hand.

A sharp scalpel is used to excise the heavy skin overlying the area of inflammation. The intra-dermal abscess is encountered, and in the base of the abscess is the opening through the true skin to a deeper abscess. Pressure in the surrounding area often produces the appearance of a drop of pus through this tiny opening. Care of this infection is simple. Under vinethene or ethyl chloride anesthesia, a mosquito hemostat is introduced through the sinus leading into the deeper abscess. By spreading the hemostat and incising into the web space, the abscess cavity is laid open. A piece of vaseline gauze may be gently inserted. A dressing with splints to immobilize the adjacent fingers is applied; hot moist dressings, antibiotic therapy, and elevation permit the rapid subsidence of such an infection in most cases.

In delayed or neglected cases the possibility of the infection extending downward along the lumbrical muscles to involve the palmar spaces is present. This must be borne in mind, but this extension has been rare in my experience.

Flexor Tendon Sheath Infections

Infections of the flexor tendon sheath are among the most disabling of all infections of the hands and fingers. They arise, almost invariably, from direct implantation of infecting organisms within the tendon sheath. The tendon sheaths of the fifth finger and thumb extend upward to the corresponding radial and ulnar bursa in the wrist, but the sheaths of the index, middle, and ring fingers stop at the distal palmar crease. The sheaths closely envelop the tendons and are composed of dense, unyielding, fibrous tissue so that great pain is produced by pressure due to the presence of even a drop or two of pus. Pain is most often at its greatest at the proximal end of the tendon sheath in the palm. There is an associated, uniform swelling of the finger. The finger is held in a position of maximum relaxation, that is, in partial flexion, and any attempt to extend or flex the finger beyond this position produces a marked increase in pain because it increases

the tension in the tendon sheath. A position of fixed flexion and a uniform swelling of the finger are diagnostic points that are almost pathognomonic.

If infection progresses, early death of the tendon may be expected because pressure shuts off all blood and lymph supply to the tendon. Fortunately, the pain produced by a tenosynovitis is so great that the patient usually seeks medical advice early. It is fortunate, also, that the infecting organism usually is a streptococcus or staphylococcus and can be well controlled by an adequate dosage of penicillin. Antibiotic treatment usually results in a subsidence of the infection without the necessity of incision. Splinting in partial flexion is extremely valuable, if only to prevent further pain.

If the pain has been of more than 24 hours' duration, incision of the tendon sheath for relief of tension is recommended in addition to penicillin therapy. Local irrigation of the open tendon sheath with penicillin solution has been recommended, but this is of doubtful value and is usually unnecessary if penicillin is administered systemically. An incision is made in the long axis of the finger along the side to enter the tendon sheath. The operation is best performed under general anesthesia and with a tourniquet to obtain a bloodless field. Postoperatively, splinting and sterile precautions with each dressing to prevent mixed infection are important.

With the use of antibiotics, the progressing slough of tendon so frequently seen in former times is now rarely encountered.

Palmar Space Infections

The insertion of the palmar fascia along the middle metacarpal bone divides the palm into two potential fascial spaces. To the ulnar side of this attachment lies the middle palmar space and to the radial side lies the thenar space. The spaces are bounded behind by the interosseous muscles and metacarpal bones and in front by the palmar fascia, the nerves, vessels, and flexor tendons which pass to the finger.

These spaces may be infected by direct implantation of infecting organisms or by the extension of infection from web space infections, or from suppurative tenosynovitis of the finger. Symptoms of these infections are quite typical. In the thenar space, there is much swelling and ballooning out of the ulnar side of the hand with pain and tenderness. Infection of the thenar

space is marked by swelling which appears to balloon out the tissues of the web of the thumb and to push the thumb away from the index finger. With infection of both of these spaces there is a rapidly appearing edema of the dorsum of the hand. Usually, finger motion, at least a small amount, may be produced without pain, unless the process began as a tenosynovitis.

These infections, too, may be successfully treated by antibiotic therapy. However, if they are of more than two or three days' duration, it is probable that suppuration has taken place and incision and drainage are indicated. To drain the middle palmar space, an incision is made in the web between the middle and ring fingers. A curved hemostat is then gently inserted over the head of the metacarpal bone into the space. Drainage of pus identifies the space, and continued drainage may be obtained by introduction of a rubber dam drain.

For drainage of the thenar space, an incision in the web of the thumb or along the thumb side of the first metacarpal bone permits a direct entrance into the space.

For all of these infections, postoperative care

consists of splinting, hot wet dressings, and meticulous aseptic technique in postoperative dressings.

However, there are other less commonly met infections that occur in the hand and fingers. Infections with mouth organisms may occur from bites or from injuries due to forks or other instruments which have been in the mouth. Butchers and handlers of seafood are frequently infected with Rosenbach's erysiploid. Happily, also, these infections respond very well to antibiotic therapy.

The seriousness of hand and finger infections has been greatly decreased by the advent of antibiotic therapy. When the process is recognized and adequately treated, surgery may usually be avoided. But, even with the antibiotics, incision and drainage are necessary if suppuration and tissue necrosis have occurred. The principles of treatment are the same as they were before we had these "wonder drugs"; however, the destructiveness of the infective process is greatly minimized by their use and earlier healing and decreased morbidity have been the fortunate result.

THE PLIGHT OF MEDICAL EDUCATION

The plight of medical education in this year 1950 is a financial one. The public has arrived at the conclusion that one of its rights is to enjoy good health. To give the kind of medical care that is wanted by this same public there must be available good, well-trained physicians. No other type will do. Modern science has brought about the advances in medicine which exist today but, as Dean George Berry recently said in addressing The Harvard Medical Society of New York, the people want proofs of this fact and are pushing the medical schools to train more doctors in order to accomplish this end.

Few physicians probably realize the plight of the medical school today. Last year 48 medical schools ran up a total deficit of 10 million dollars. The total medical school budget for 1949 was 51 million dollars. Is it any wonder that the tuition of a medical school student now covers less than 25 per cent of the cost of his medical school education when that cost has doubled in the last seven years? In 1920 it cost approximately \$500 per student per year to deliver a medical school education; now the cost is \$2,500 per student per year, and in this current year the medical school budget of the nation is going up to an all-time high of 61 million dollars.

Many medical schools are faced with the serious threat of being obliged to close their doors. Because of this and the diminishing purchasing power of endowment income, Dean Berry argues that medical schools

must have Federal aid. He estimates the total annual cost to the government at 40 million dollars. He would maintain a balance between Federal aid and private support and believes, a bit naively perhaps, that by so doing Federal control of the medical schools can be prevented. In 1949 Harvard Medical School suffered a deficit of \$100,000. In 1951 the deficit is expected to be at least three times that amount. If such a sizable deficit is experienced by a school which enjoys membership in the richest university in this country, what must be the plight of many a less fortunate medical school?

The solution is not an easy one. Already medical tuitions have climbed out of reach of the common man, necessitating an increase in scholarship aid for the first two years and sizable student loans for the last two years. Most university presidents are thought to consider medical schools as parasites of the universities. The cost of the education of the doctor of medicine is the highest of any profession today. Must Federal aid be sought and accepted? If so, can it be received by the right hand while the left hand reaches out for what little private enterprise can give? And can our medical schools maintain their independence from political domination if they accept gratuities from Washington? History would seem to reply in the negative.

In spite of the cost there were 7066 medical students who began their medical education last year. The art of healing continues to attract youth. Some means must be found to finance the training in the science of healing.—*Connecticut State Medical Journal*

The Diagnosis and Treatment of Allergic Rhinitis

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ALLERGIC rhinitis is one of the most important and significant manifestations of hypersensitivity which faces the practicing physician. It is all too often unrecognized in its milder or earlier forms and when recognized is apt to be regarded lightly or inadequately treated. The responsibility for such a situation rests partly upon the shoulders of the patient and partly upon those of the doctor.

Patients have a tendency to regard frequent sneezing or nasal occlusion as humorous or of little consequence and report for treatment only when advanced complications have developed. On the other hand, physicians who are zealous in their quest for symptoms referable to the cardiovascular system or gastro-intestinal tract often neglect to interrogate the patient with respect to less outstanding symptoms which might indicate nasal allergy. Apparently this is due, at least partly, to lack of understanding of the tremendous potential of this condition.

Our problem is well illustrated by a case admitted to one of our allergy clinics Sept. 22, 1950. A 4-year-old boy was referred from the pediatric clinic because of asthma. His history indicated that from the age of six months he had perennial symptoms of almost constant rhinorrhea, frequent paroxysmal sneezing, and much nasal itching. In November, 1949, at the age of three, persistent non-productive cough and dyspnea developed. Medical attention was sought and for six months he received local nose and throat treatment without change in his symptoms. In May, 1950, the cough and dyspnea subsided and he was free of these symptoms until September, 1950, when typical asthma appeared and he was seen in the pediatric clinic from which he was referred to allergy.

This boy was said to have no family history of hypersensitivity, but while interviewed his mother held a handkerchief in one hand, sniffed fre-

quently, and alternately rubbed and blew her nose. Questioning revealed that for 20 years or more she herself was rarely free of these symptoms of allergic rhinitis.

Any allergist can testify that this is an all too common case history.

Three years ago, in discussing perennial allergic rhinitis, Dr. Richard A. Kern¹ reported a series of 516 cases of respiratory allergy. Of these, 69 per cent had perennial nasal allergy, 50 per cent had seasonal hay fever, and 59.5 per cent had asthma. He indicated that perennial allergic rhinitis is the most common allergic disorder of the respiratory tract.

Dr. W. C. Spain² reviewed 300 cases of respiratory allergy. Of these, 38 per cent were cases of asthma, 44 per cent were cases of pollinosis, while 18 per cent were cases of non-seasonal coryza. He pointed out that 62 per cent of these cases were of allergic coryza.

In our own observation of 457 recent cases with presenting complaints of asthma, 214 or 46.8 per cent had symptoms suggesting allergic rhinitis and preceding the development of asthma. Of 113 patients presenting themselves with a chief complaint of perennial nasal allergy, 36 or nearly one-third also had asthma of some degree.

One cannot escape the impression that allergic rhinitis is the predecessor of asthma in nearly half the cases seen. Vital statistics for 1940³ indicate that in United States that year 9000 deaths associated with asthma were reported and, of these, 2233 were uncomplicated by other factors. With these facts in mind the importance of allergic rhinitis cannot be minimized.

Let us consider the more important features of the diagnosis and management of perennial nasal allergy.

Unfortunately, there is no uniform pattern of symptomatology to guide us in making such a diagnosis. The cases most frequently seen are individuals who have frequent, but brief, at-

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tacks of nasal itching and sneezing, presumably after transient exposure to a given allergen. Such attacks occur in the absence of any evidence of the common cold; they are prone to appear and disappear quickly and without evident aftermath of the common infectious condition. The patient himself may become aware of the fact that these episodes occur after exposure to house dust during cleaning or after some other unusual contact. The lack of temperature elevation and the short duration are factors pointing towards the possibility of an allergic etiology. In such instances the intranasal picture may present little abnormality other than profuse watery mucus that may contain eosinophils in excess.

When contact with the offending substance or substances is more frequent, symptoms become more constant. Nasal occlusion of some degree is apt to supplant sneezing and itching as the most prominent symptom. In the majority of these instances the development of discomfort has been so gradual that the patients have become accustomed to it and accept it as normal. It is only when usual activity is consistently interrupted by such symptoms that the majority of patients seek medical aid. When observed, the nasal mucosa has usually lost its normal stability and healthy pink color. Instead it appears extremely pale, boggy, and edematous.

A mucous membrane constantly or frequently in this condition invites invasion by pathogenic organisms. These readily oblige and not infrequently an infectious sinusitis is the thing that sends the patient to his doctor. The symptoms and findings of the acute condition tend to mask the underlying allergy. It is therefore necessary to have an adequate index of suspicion in order to elicit the history suggesting allergic factors and to observe the underlying pallor and edema most readily seen elsewhere than in the areas of sinus drainage.

It has been emphasized by Kern¹ that the protracted presence of infection in the allergic nose results in a gradual series of changes including a firmer edema, diminished ciliary action, and impairment of drainage. The end results of such changes are mucous polyps which arise primarily in close relation to the sinus ostia and may extend into the sinuses as well as into the nose. Kern and Schenck⁴ have indicated that the antra are more frequently involved than the nasal chambers. Polyps clinically produce an ever increasing degree of nasal occlusion which may

persist even without constant exposure to antigen.

Persistently recurring attacks of the type described plus a rather characteristic intranasal picture lead to a preliminary or working diagnosis. However, one cannot proceed from the indications of the existence of this condition to active therapy. For adequate management a further and more specific etiologic diagnosis is mandatory. Complicating factors, such as structural abnormalities, also demand consideration.

It is an accepted rule that the earlier a diagnosis of malignancy is made the more amenable it is to treatment. So it is with all allergic conditions, and perennial nasal allergy is no exception.

A careful and painstaking history is invaluable and must delve into such matters as the times of onset and offset of symptoms, their relationship to climate, location, season, and contact with possible causative agents. Minute details of occupation, hobbies, and all phases of environment should be enumerated.

In addition to an ordinary complete physical examination, the services of a competent and experienced rhinologist and an equally competent and experienced radiologist should be utilized when possible. Only in this manner can we ascertain most completely the condition of the less readily accessible sinus areas. A biopsy of polyps should be done in order to rule out neoplasm. Mucous polyps when conclusively demonstrated are evidence of underlying nasal allergy.⁴

Skin tests for hypersensitivity are essential and must be carefully evaluated in the light of the clinical picture and the experience of the observer. They should not be wholly delegated to a technical assistant. The choice of materials to be tested may vary from one individual patient to another, but in each instance should include common inhalant substances such as feathers, common animal danders, wool, cottonseed, tobacco, pyrethrum, orris root, kapok, flaxseed, karaya gum, and glue. Common pollens of the geographic area should also be included because unsuspected hay fever frequently exists. One should never omit the patient's own house dust. Foods may or may not be included, depending upon the indications in the history or the convenience of subsequent observation of the patient.

It is well to inform each patient that the first study may not prove to be completely adequate when put to trial, and that allergic patterns may

change from time to time. Hence subsequent study may be necessary.

Since human beings are not the product of construction engineers, and since diagnostic procedures cannot be formulated mathematically, the final and clinching diagnostic measure is trial therapy.

When a working diagnostic pattern has been established, treatment falls logically into a number of categories:

1. *Complete Avoidance of All Agents Indicated to Be Possible Offenders.* Sir William Osler is reputed to have said "the practice of medicine is a compromise." Perhaps so, but here it is a compromise to be avoided, if humanly possible, even to the elimination of household pets and some of the luxuries of modern living such as soft feather pillows, lovely draperies, and lush carpets, particularly in the bedroom where the greater number of one's living hours are spent. Foods may present difficulties and often tax the ingenuity of patient and physician to find adequate and satisfying substitutes, or to locate the many hidden ingredients which may be incorporated in the multitude of processed foods of our age.

Pollens, mold spores, and organic dusts may also present difficulties, for it is impractical, as a rule, for most of us to take off on a round-the-world cruise each pollen season, or to pull up roots completely and change occupation or the area in which we live or all of our household furnishings.

When complete avoidance is impossible or impractical, we resort to:

2. *Partial Avoidance.* Experience has indicated that the production of allergic symptoms is the result of the summation of antigenic forces. Exposure to a small amount of allergen may produce no symptoms, a little more exposure may produce moderate symptoms, and still more exposure may produce severe symptoms. Or one factor alone may be insufficient to produce trouble where two or more combined may result in marked difficulty. Minimizing exposure to offending substances may therefore reduce the allergenic activity to a point below the threshold of symptomatology. A common example of partial avoidance is the preparation of a bedroom so that it produces and retains a minimum of organic dust.

When complete avoidance is impossible and

when partial avoidance is inadequate to produce results, we proceed to:

3. *Hyposensitization.* This is done by a gradually increasing exposure to the offending material starting with a dose too small to produce symptoms and increasing the dose gradually, aiming at a top amount that will result in adequate protection in the face of ordinary degrees of exposure. With the few foods where this procedure may be indicated, the oral route is used. In the case of inhalants, such as house dust, subcutaneous administration is in order. Particularly in the latter procedure one must proceed with caution, for the weapon used may be a two-edged sword and too frequent dosage, too large increases in the dosage, or incorrect extracts may produce, rather than prevent, trouble.

4. *Treatment of Complications.* Those complications most often requiring attention are obstructing septal deflections, polypoid tissue that remains after several months of thorough straightforward allergic treatment, or large obstructing polyps and sinusitis.

Surgery should be avoided during the pollen season because of the danger of inducing pollinosis which did not previously exist. In the case of large obstructing polyps, or some cases of acute purulent sinusitis, this rule may not be tenable. Sinus surgery, when carried out, should be thorough and not temporizing, although it is desirable to avoid doing too much at one time. Post-operative care should be meticulous in order to prevent adhesions or further infection.

Autogenous vaccines are extremely helpful in those cases in which infection is a factor. Bacterial allergy is not infrequent and must be deduced by the process of elimination aided by suggestive chronicity and lack of association of symptoms with location or other extrinsic factors. It cannot be detected by skin tests.

5. *Symptomatic Measures.* These are frequently helpful, but are sometimes used ill-advisedly to the exclusion of adequate diagnosis and treatment. They should be used as adjuncts only to relieve acute symptoms when thorough study is not immediately available, while specific diagnostic and therapeutic measures are in process, or when unusual exposure to allergens produces trouble in the face of active therapy.

Symptomatic relief may be obtained at times by the use of many different drugs and materials, none of which is curative, and none of which alter the underlying sensitivities in any perma-

nent degree. Those most commonly used with some effectiveness include intranasal shrinking solutions, atropine, the various sympathomimetic drugs, and the so-called antihistaminics. They are not without hazard, especially when injudiciously used or self-prescribed by the patient. Intranasal medication may induce secondary irritation, drug allergy may be induced or, by developing a tolerance, the patient may lose an effective agent which might otherwise assist in tiding him over an acute crisis. Some drugs have not infrequent and disagreeable side effects. This is particularly true of the antihistaminics which have a definite place in our armamentarium, but which are by no means the answer to the search for a simple and direct key to the secrets of allergic disease. It should be remembered that these drugs tend to diminish reactions at the sites of skin testing and patients should be warned to take no such medication for a period of preferably 12 hours or more before reporting for studies.

More recently ACTH and cortisone have been under scrutiny as to their effectiveness in allergic conditions which have included perennial nasal allergy and pollinosis. Success has been reported, but the relief obtained has been apparently confined to the period during and immediately

following the time when the preparations were being administered.^{5, 6}

Estimates vary, but anti-allergic therapy based on thoroughly adequate diagnostic study will produce relief satisfactory in degree and duration in an average of 85 per cent of cases.

Summary

Allergic rhinitis is the most common respiratory allergic disease encountered. It has many and distressing complications and all too often is a prelude to asthma. For various reasons it is frequently long unrecognized or neglected. Good results can be anticipated by thorough investigation and treatment along allergic lines. These facts indicate logically the desirability of adequate diagnosis and treatment of even the mildest cases.

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LISTEN!

"Anyone who calls a spade a spade should be compelled to use one."

One major condition resulting in the flourishing of cultism toward which we are not concerned here is the fundamental conservatism of the medical profession. This can be illustrated by citing the case of a patient with continuing local pain following shingles who was told by his family physician that about three months would elapse before the annoying, not incapacitating pain would disappear. The patient consulted a cultist and was told that by the use of bi-weekly treatments of "shots and light" this affliction could be rectified. Before the twelve weeks were up the patient realized the forethought of his family physician and discontinued the cultist form of treatment.

The other aspect is one upon which this essay is concerned, and it is in this province that the cultist can, and too frequently does, compete with the medical practitioner. This is in a sympathetic attitude which is usually expressed in listening. Early in the clinical years in medical school the student learns about the avidity of the patient to relay his symptoms with exhausting attention to detail and trivia with scant bearing upon value as relevant information. The patient's attempts to metaphor or describe his pains are much

greater than his accuracy as to the time and mode of onset. His fondness for the wayside of non-essential data and the difficulty of keeping him on the hard road of salient information is well known—so doctors become impatient with their patients. That they have provocations can be understood, but becoming impatient and showing it are vastly different things.

Patients go to the cultists, not for better care, but for a sympathy and attitude and a willingness to allow time that is not usually received from the busy doctor of medicine. In other words, a competent physician can ascertain more in twenty seconds of listening to a heart than a senior medical student can in twenty minutes. Too many patients like the seemingly more careful *because it took longer* examination. It is obvious that competency cannot be judged by a stop watch; it is done, however, because it is easy. That it is also inaccurate is apparent to all except the one who does the judging.

If psychiatry can use the "talking out technique" of abolishing a patient's problem, perhaps more of us can practice this art with profit. It is here that the cultist makes his chief inroads into the practice of the healing art. He listens, often without interruptions, and has, if not a better, a more grateful patient. Much of the art of medicine resolves itself into the art of listening.—*Detroit Medical News*, July 10, 1950.

POLIOMYELITIS

A Study of 320 Cases

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DURING the past few years there has been an increase in the incidence of acute anterior poliomyelitis in this country. Coincidental with this there has also been an increase each year in the number of patients with poliomyelitis admitted to the Geisinger Memorial Hospital in Danville. The hospital admits patients not only from Montour County where the hospital is located but also from the surrounding counties within a radius of approximately fifty miles.

The first patient with acute poliomyelitis was admitted to the Geisinger Memorial Hospital in 1927. From that year up to 1941 from none up to 7 patients were admitted each year, and altogether 38 patients were treated and there were 7 deaths. In 1941 the first epidemic occurred with the admission of 49 cases. Lemmon¹ published a report of this epidemic in 1942.

In 1942 and 1943 again only a few patients were admitted, but in 1944 the figure rose to 41 cases. Since that year the incidence has gradually increased with 15 cases in 1945, 16 cases in 1946, 64 cases in 1947, 80 cases in 1948, and 104 cases in 1949. Although the number of patients admitted has gradually increased each year, the number of counties from which the patients have come has remained the same.

In this paper I wish to give a report on the patients admitted to the Geisinger Memorial Hospital from June, 1944, through December, 1949.

Material

During the six-year period 320 patients were admitted to the hospital during the acute stage of poliomyelitis. There were 178 males and 142 females. The youngest child was 6 months of age and the oldest patient was 45 years. In Table I

may be seen the age distribution of the cases. It may be noted that there were 6 children under one year of age and the age group from 5 years to 9 years was the largest. Two hundred and thirty-nine or 74.7 per cent of the patients were under 15 years of age and only 81 or 25.3 per cent were over 15 years.

In Table II may be seen the number of cases admitted each year, the classification according to the degree of paralysis, the number of bulbar cases, and the mortality rate. There were 45 cases diagnosed as non-paralytic. These patients had only mild involvement of the central nervous system and had no weakness or paralysis at the time of discharge from the hospital, which was at the end of the 14-day quarantine period. The paralytic group comprised 78.7 per cent of the total number of patients. Thirty-three patients had bulbar poliomyelitis and 10 of these had some spinal involvement also. Twenty-one patients had evidence of tenth nerve involvement and 10 patients had encephalitis.

Diagnosis

It might be worth while to discuss our method of arriving at a diagnosis of poliomyelitis. When a patient is admitted to the hospital, he is placed in a special isolation unit. A careful and com-

TABLE I
INCIDENCE OF POLIOMYELITIS ACCORDING TO AGE

<i>Age (Years)</i>	<i>No. of Cases</i>	<i>Per Cent of Cases</i>
0-11 mos.	6	1.9
1- 4	78	24.4
5- 9	85	26.6
10-14	70	21.8
15-19	45	14.1
20-29	26	8.1
30+	10	3.1

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From the Geisinger Memorial Hospital, Danville, Pa.

TABLE II
INCIDENCE OF POLIOMYELITIS EACH YEAR, TYPE OF CASE, AND MORTALITY RATE

Year	Total Cases	Non- paralytic		Paralytic						Bulbar*		Deaths	
				Mild		Moderate		Severe					
		No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
1944	41	2	4.9	5	11.9	9	21.9	18	43.8	7	17.5	6	14.6
1945	15	2	13.3	2	13.3	4	26.8	2	13.3	5	33.3	1	6.6
1946	16	1	6.2	1	6.2	6	37.5	6	37.5	2	12.6	2	12.5
1947	64	5	7.8	18	28.1	22	34.4	14	21.9	5	7.8	2	3.1
1948	80	15	18.7	20	25.0	20	25.0	17	21.3	8	10.0	6	7.5
1949	104	20	19.2	30	28.8	25	24.0	23	22.2	6	5.8	2	1.9
Total	320	45	14.0	76	23.8	86	26.9	80	25.0	33	10.3	19	5.9

* Ten of these patients had some spinal symptoms also.

plete history is taken and certain symptoms compatible with the onset of the disease are noted. These include fever, which may be as high as 104 degrees, severe prolonged headache, marked malaise, nausea and vomiting, stiffness of the neck and usually the back, and tightness of the hamstrings. Constipation is usually present and frequently sore throat.

A thorough physical examination is then carried out. There is a group of symptoms that are almost always present in an acute case of poliomyelitis. The patient looks acutely ill. He will lie very quietly in bed on the back with the arms at the sides. Movement is reduced to a minimum, even in young children, and there is very little talking. When disturbed the patient becomes irritable and cries easily. The stiffness of the neck and back makes it difficult for the

patient to sit up without assistance. Movements are awkward and it is necessary to push with the arms or use the sides of the crib if a child. The spasm of the hamstrings makes it impossible to sit up without flexing the knees and supporting the back with the hands behind the body. The presence of further central nervous system involvement is noted by weakness of one or more muscle groups, tremulousness of the musculature, incoordination, spasticity, tenderness, hyperaesthesia, or definite paralysis. Evidence of bulbar involvement is carefully noted.

If the history and physical examination are compatible with poliomyelitis, a clinical diagnosis of the disease is made. A spinal tap is then carried out to confirm the diagnosis. If the spinal fluid shows an increase in the cell count and/or an increase in the protein, the patient is moved

TABLE III
RELATION OF CELL COUNT IN THE SPINAL FLUID TO DAY OF DISEASE

Day of Disease	No. of Samples	Cells Per Cubic Millimeter					Per Cent Elevated
		0-9	10-49	50-99	100-199	200+	
1	34	22	5	2	3	2	35.3
2	40	10	18	4	5	3	75.0
3	58	14	15	10	13	6	75.0
4	70	11	10	20	15	14	84.3
5	33	5	13	4	8	3	84.9
6	28	4	9	8	5	2	85.7
7	33	5	16	6	2	4	84.9
8	16	7	6	1	2		56.3
10	24	16	4	3	1		33.3
12	6	4	2				33.3
14	11	9	3				18.2
21	11	11					0

to a poliomyelitis unit and treatment is instituted. If the spinal fluid is normal and marked paralysis is not present, the patient is kept under observation and, if possible, a repeat spinal tap is carried out. After at least three days, if the patient continues to have clinical evidence of poliomyelitis, a diagnosis of the disease is made in spite of the normal spinal fluid findings and the patient is treated. A study of the patients with normal spinal fluid findings has been previously reported.² Most cases of poliomyelitis are easy to diagnose, but in some instances careful judgment must be exercised as many cripples are the result of missed cases.

In evaluating the results of the findings of the spinal tap, many factors must be taken into consideration. Perhaps one of the most important of these is the day of the disease when the tap is done (see Table III). In a high percentage of cases the cell count is normal in the spinal fluid within 24 hours after the onset of the disease. The cell count is most likely to be elevated between the fourth and the seventh day. It gradually tapers off at the end of the first week and the protein tends to increase (see Table IV).

Treatment

There is no specific antibiotic therapy at the present time for the treatment of poliomyelitis. The chief aim is to save the life of the patient and prevent as much crippling as possible. In the Geisinger Hospital the patients are kept in small units of four to six to a room. An attempt is made to keep patients of the same age group together. Also, acutely ill patients are not kept in the same room with those who are con-

valescing. Respirator cases are put in individual rooms. Nursing care is considered of paramount importance and all nurses who have charge of the patients are graduates who have had special training in the treatment of poliomyelitis. Each nurse has the care of three or four patients and is on eight-hour duty.

Every patient has a board placed beneath the mattress and a foot board. Hot packs are used for all patients who have spinal poliomyelitis. The packs are applied four times a day, between the hours of five in the morning and ten o'clock at night. Packs are not applied during the night, except in very severe cases, as they tend to interfere with sleep. During the past few years we have devised a new form of hot pack which is very efficient and highly satisfactory. A bath blanket is warmed by steam in the spinner and wrapped around the patient. Two or three heavy, wool blankets and a rubber sheet are also applied and the pack is left on for half an hour. This type of hot pack is easy to apply and stays warmer longer than the individual wool packs.

All patients are given penicillin if the temperature is markedly elevated. They are given multiple vitamins, liberal fluids, and a good nourishing diet. Specific therapy is used when indicated. Physiotherapy is started according to the progress of the patient and continued throughout the hospital stay. Follow-up is carried out on all patients who are able to return to the hospital, and severely paralyzed cases are referred to convalescent hospitals for further care.

In poliomyelitis, perhaps more than most diseases, it is important to keep up the morale of the patient and also of the family. With this in

TABLE IV
AMOUNT OF PROTEIN IN SPINAL FLUID IN RELATION TO DAY OF DISEASE

Day of Disease	No. of Samples	Amount of Protein			Per Cent Elevated
		0-59 mg.	60-99 mg.	100+ mg.	
1	26	26	0	0	0
2	38	26	10	2	31.6
3	54	32	16	6	40.7
4	67	35	26	6	47.7
5	31	16	9	6	48.3
6	23	11	9	3	52.1
7	33	10	17	6	66.6
8	24	8	10	6	66.6
10	19	6	9	4	68.4
14	14	5	4	5	69.2
21+	10	3	3	4	70.0

TABLE V
STUDY OF THE SEX, AGE, AND TYPE OF POLIOMYELITIS IN THE 19 PATIENTS WHO DIED

Sex				Age (Years)									
Male		Female		0-14		15-40		Severe Spinal		Bulbo-spinal †		Encephalitis	
No.	Per Cent*	No.	Per Cent*	No.	Per Cent*	No.	Per Cent*	No.	Per Cent	No.	Per Cent	No.	Per Cent
13	7.3	6	4.2	9	3.7	10	12.3	4	21	12	63.1	3	15.9

* Percentages based on total number of patients in each group. † Nine patients had tenth nerve involvement.

mind the parents of a patient are called into the doctor's office as soon as a diagnosis is made. The severity of the case is discussed and the treatment to be carried out is outlined. Parents are encouraged to call the physician in charge of the case at any time regarding the progress of the patient. Patients are permitted to have near relatives visit them once a day for one hour. If a patient is acutely ill, however, the time may be reduced to ten minutes or less. Toys, books, radios, and anything to help the patients are permitted.

Time does not permit a detailed report on the treatment of bulbar and respiratory cases. Difficulty in swallowing, slurred speech, and absence of the cough reflex are indications of tenth nerve involvement. The foot of the bed should be elevated and removal of the pooled saliva in the throat by suction should be instituted. Fluids should be given parenterally. Tracheotomy should be carried out if necessary (see Stimson³ and Baker⁴). All patients with weakness or paralysis of the muscles of the upper arms and shoulder girdle should be watched carefully for the development of paralysis of the muscles of respiration. It is unwise to put a patient into a respirator until all other measures fail. However, in the presence of anoxia as evidenced by unconsciousness, rapid heart action, and twitch-

ing around the corners of the mouth, the patient should be put into the respirator at once.

Results

In Table II may be seen the distribution of the various types of poliomyelitis in the 320 cases. There were only 45 patients or 14 per cent classified as non-paralytic. It may be noted that this varied from year to year, according to the severity of the epidemic. This figure is lower than is usually reported in the literature and is no doubt due to the fact that we are reluctant to diagnose a case as poliomyelitis unless there is a clear-cut picture of the disease and also definite evidence of central nervous system involvement.

About 78.7 per cent of the patients had spinal poliomyelitis and the type was about equally divided between mild, moderate, and severe. In Table VI may be seen the results of recovery according to age of the patient. Up to 4 years of age the amount of permanent crippling was surprisingly high, although the mortality rate was low. Permanent paralysis was low between the ages of 5 and 15 years. The age group from 15 to 19 years had the highest rate of permanent damage and a high mortality rate. After 20 years the paralysis decreased, but the mortality rate rapidly increased.

In Table II may also be seen the mortality

TABLE VI
RECOVERY FROM ACUTE POLIOMYELITIS AND MORTALITY RATE ACCORDING TO AGE

Age (Years)	Total Cases	Complete Recovery		Residual Paralysis		Deaths	
		No.	Per Cent	No.	Per Cent	No.	Per Cent
0-4	84	47	55.9	34	40.5	3	3.6
5-9	85	59	69.0	21	25.1	5	5.9
10-14	70	46	65.7	23	32.9	1	1.4
15-19	45	18	40.0	23	51.2	4	8.8
20-29	26	12	46.1	11	42.4	3	11.5
30+	10	4	40.0	3	30.0	3	30.0
Total	320	187	58.3	114	36.8	19	5.9

rate for the years 1944 through 1949. In 1928, 1931, and 1933 when 7 patients each were admitted to the hospital, the mortality rates were 28.5 per cent, 28.5 per cent, and 42.8 per cent respectively. In 1941 the rate was 12 per cent. The mortality rate has gradually decreased since 1946 and in 1949 it was 1.9 per cent. This decrease is probably not due to a less severe form of the disease but rather to early diagnosis and a better knowledge of the treatment of the severe cases and especially the bulbar types. Of the 320 cases seen during the past six years, there were 19 deaths or a mortality rate of 5.9 per cent. Thirteen of the patients were males and 6 females. Nine of the patients were under 15 years of age and, as there were 239 patients in this group, the rate is 3.7 per cent. Ten patients were over 15 years of age and the mortality rate for the 81 patients in this group is 12.3 per cent (see Table V). In Table VI may be seen the rate of mortality according to the different age groups. The rate was lowest in the 10 to 14 year group and there was a sharp rise after 30 years of age.

Twelve patients had severe paralysis with involvement of the chest muscles and had to be put in respirators. Four of these died and eight or 66.6 per cent survived and all were able to be taken out of the respirators completely except one who had to be put in at night to sleep. There were 24 patients with bulbo-spinal poliomyelitis and 21 of these had tenth nerve involvement. Twelve or 50 per cent died and the remaining 12 patients who were all under 15 years of age made a complete recovery. Ten patients had encephalitis and there were 3 deaths. The 7 cases which recovered were in the younger age group.

Summary

From June, 1944, through December, 1949, 320 patients with acute poliomyelitis were ad-

mitted to the Geisinger Memorial Hospital. The number of cases treated each year has gradually increased from 41 in 1944 to 104 in 1949. The incidence of poliomyelitis has increased in the community, as the number of counties from which the patients have come has remained the same.

Of the 320 cases, 45 were non-paralytic, 242 had various degrees of paralysis, and 33 were bulbar. There were 19 deaths, or a mortality rate of 5.9 per cent. Twelve patients had severe spinal poliomyelitis and had to be put in respirators. There were 4 deaths and the remaining 8 patients were able to be taken out of the respirator, except one who had to be in at night. There were 24 patients who had bulbo-spinal poliomyelitis and 21 of these had tenth nerve involvement. Twelve or 50 per cent of these patients died. Ten patients had encephalitis and there were 3 deaths.

In the analysis of the outcome of this disease according to age, it was found that the amount of crippling and the mortality rate are lowest from 5 to 15 years of age. The degree of paralysis is highest from 15 to 19 years. After 20 years the amount of permanent damage decreases but the mortality rate rapidly increases.

For best results in the treatment of this disease, early diagnosis and good nursing care are of paramount importance and a physician should be in charge who has had special training and wide experience in the care of poliomyelitis patients.

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Adequate dosage of antibiotics and chemotherapeutic agents and timely surgical intervention are of equal value in the prevention and control of infection, as is wisely set forth on page 1257.

Management of Patients with Intermittent Claudication

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INTERMITTENT claudication is the most common symptom in patients with occlusion of arteries in the legs. The occlusion may have occurred as the result of arteriosclerosis, thromboangiitis obliterans, or embolism. The symptom is a difficult one to relieve as indicated by the number of methods introduced for treating it. Several vasodilator drugs are used at the present time for patients with arterial disease in the legs. Priscoline, 50 milligrams four times a day, and whiskey, one ounce twice a day, produce mild vasodilatation in the skin of some individuals. Nicotinic acid will often produce vasodilatation in the face, but not in the extremities. It should be remembered that drugs that cause warming of the skin may not necessarily increase blood flow to the muscles. The evidence is against any drugs mentioned increasing blood flow to leg muscles. Priscoline and whiskey are useful where increased blood flow is required to heal or prevent an ischemic lesion on the skin or for vasospastic conditions, but are probably of no value for the symptom of claudication.

Blocking of the sympathetic ganglia temporarily, several times, by means of paravertebral block with procaine or tetra-ethyl-ammonium chloride will relieve the symptom of claudication in a small minority of patients. The relief is probably not through an increase in blood flow, but the result of relieving a causalgic state set up in nerves damaged either by inflammation as in thromboangiitis obliterans or by severe ischemia to nerves as in arteriosclerosis or embolism. Lumbar sympathectomy may be limb-saving in severe ischemia but is not indicated for the symptom of claudication alone. It has been found that although a lumbar sympathectomy may cause a marked rise in skin temperature of the feet and legs it does not increase blood flow to the leg muscles. Although the suction and pressure apparatus is used much less now than it

was formerly, some patients seem to improve their walking distance following this procedure. There is little evidence that the intermittent venous compression apparatus increases blood flow to the skin or muscles. Tissue extracts are of no value in intermittent claudication. Intra-arterial injections of drugs such as histamine, papaverine, and priscoline have little or no place in the treatment of this symptom. Even multiple transfusions of blood into the ischemic leg have been used for the symptom. Buerger exercises are sometimes recommended for the symptom of claudication, but it is difficult to see how this type of exercise, done for short periods each day, can influence this symptom. An occasional patient seems to have marked improvement of claudication simply as the result of stopping the use of tobacco, possibly by preventing vasospasm.

Although many patients obtain improvement in walking ability with treatment, there is still a large group who are unable to walk without claudication despite treatment. Because there is this large group of patients who are unable to walk more than a block or two without stopping, a study of such patients was carried out at the University Hospital.¹ Since there was a limit beyond which one could not increase the blood supply to the leg muscles in patients with occlusion of the major artery, the idea suggested itself that perhaps one could do something about reducing the demand for blood by these muscles so that it would more closely approximate the reduced supply. If this could be done, perhaps limping could be delayed or prevented. An investigation was therefore set up during which patients were taken outdoors and advised to walk as they did ordinarily with an observer walking beside them. As soon as walking started, a stopwatch was started and a counter used to determine the rate of walking as well as the time of onset of fatigue and the distance which could be walked without stopping.

It was found very quickly that most of the patients were walking just as rapidly as did the average normal person, despite the fact that they

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From the Peripheral Vascular Section of the Edward B. Robinette Foundation, Medical Clinic, Hospital of the University of Pennsylvania.

had thought they were walking more slowly before the onset of pain. What was happening was that they were walking at the regular normal rate and slowed down only when pain began to appear in the foot, calf, or thigh at the end of a block or two. They were actually walking at the rate of 110 to 120 steps per minute, which is the walking rate of the average normal person. They would slow up or stop only when pain would come on and then would rest until the pain subsided and would start walking again. The patient thinks he is walking more slowly only because it takes him longer to get to his destination. Very few of the patients, only those with extreme ischemia, slowed up before fatigue or pain appeared.

When they were taught to walk at a rate of 90 to 95 steps per minute instead of their usual gait, many patients who could not walk a block at the more rapid rate were able to walk many blocks at the slower rate. This was done by simply reducing the walking rate, not only when they had pain but at the very start of walking. A number of patients who had been unable to perform essential duties which might require walking two or three blocks were able to walk this distance comfortably without fatigue by simply reducing their walking rate to 90 steps per minute. This simple procedure reduced the demand for blood so that the need more closely approximated the supply and patients were enabled to walk along strolling for many blocks with less or no discomfort. Paradoxically, patients were able to get to their destination sooner at the slower rate than when walking more rapidly, because they did not have to stop and rest at each block for relief of the symptom of claudication. For example, a patient walking at the rate of 120 steps per minute and having intermittent claudication which required resting for a minute at the end of each block took 11 minutes to walk four blocks. On the other hand, when a patient would walk at the rate of 95 steps per minute and did not have to stop because of claudication, he was able to walk the same four blocks in 10 minutes without pain and without stopping.

It was also found that claudication was lessened if patients shortened their step. When claudication did appear or pain was severe, it was found that shifting the weight to the better leg permitted the symptom to disappear more rapidly. Several patients had also found that if they held the knee of the affected leg straight or in a semi-stiff position they were able to walk

much better as the result of placing most of the weight on the better leg. This method enabled these patients to increase their walking ability by four or five times. What they were doing was substituting a mild constant limp for severe intermittent claudication. Boyd and his associates² in England attempted to accomplish a similar purpose surgically by cutting the Achilles tendon just above the heel with a tenotome.

It is not always easy for a patient to slow down before claudication begins. Patients walk at a certain rate to which they have been accustomed for many years. Very often these patients will have to be shown that if they walk more slowly they can get farther with less pain. Some of them can simply be told to learn to walk at the rate of 90 to 95 steps a minute or perhaps to stroll along.

There is no limitation to the amount of walking since this is a good method of producing vasodilatation in the leg, provided it is not done to the point of pain.

Patients with intermittent claudication must not only be treated for this symptom but must be taught the usual precautions that they must take to prevent a break in the skin which may precipitate gangrene. Probably the most important single thing to be done for these patients is to hand them a printed instruction sheet on care of the feet since any small crack between the toes or fissure on the heel may lead to ulceration and gangrene. Stopping of smoking is essential in patients with thromboangiitis obliterans and is important in arteriosclerotic patients with severe ischemia. Also, a diet low in fat and cholesterol should be recommended to patients with arteriosclerosis.

Summary

Intermittent claudication is a difficult symptom to improve. Drugs and procedures that increase blood flow to the skin do not necessarily increase the circulation to leg muscles.

Teaching patients to walk at a rate of 90 to 95 steps per minute instead of the normal rate of 110 to 120 steps enables many of them to walk much farther and often without claudication.

Prophylactic care of the skin to prevent gangrene is important in these patients.

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Portable Diabetic Coma Treatment Stand

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THIS portable diabetic coma treatment unit was developed to enable physicians, residents, interns, and nurses to provide more rapid and efficient handling of emergency problems in diabetic patients. The unit is so arranged that it is portable and ready for immediate use. This equipment saves much wasted time in the initial treatment of the patient in diabetic acidosis or coma, and has eliminated the difficult task of getting materials together during rush hours in the daytime, or during the absence of regular personnel at night. This unit is really intended for use in the larger general hospital, but it might well be useful in any hospital.

In our experience, this portable diabetic coma treatment stand may be used in the hospital emergency room, on the obstetric, pediatric, surgical, or medical floors, as a replacement temporarily of the patient's bedside stand.

This unit is probably far from perfect, but thus far its efficiency has been proved to be satisfactory. The only problem has been the transfer of insulin products from the refrigerator to the treatment stand prior to putting the equipment in use.

In a compact manner, this portable treatment stand helps to crystallize early and efficient diabetic coma treatment without any personal restrictions in the method of treatment. Dr. Elliott P. Joslin's recommended technique in the treatment of diabetic coma has been appended merely for reference purposes for those who are interested in a standard outline of treatment. Also, data on the differential diagnosis of coma is included for reference.

Directions for Use of Diabetic Coma Treatment Stand

1. Call service department (be certain that insulin, etc., is transferred to the treatment stand).
2. Portable unit should be placed beside patient's bed, or it may be used in the emergency, obstetric, pediatric, or other departments.

From the Medical Department, Mercy Hospital, Pittsburgh, Pa.

3. Equipment, plainly marked:

- A. Blood collection apparatus for blood sugar, etc.
 - B. Urinalysis equipment for urine sugar (Clinitest), acetone, and diacetic acid are provided.
 - C. Regular and crystalline (U 40) insulin provided with sterile syringes, needles, gauze, and alcohol 70 per cent.
 - D. Intravenous solutions.
 - E. Diabetic and nurses' charts.
 - F. Examination equipment.
 - G. Catheterization tray.
4. Unit to remain at patient's bedside as long as required, and then to be returned to the service department.
 5. Reasonable care in transfer of unit and use of equipment will be expected.
 6. Physicians' and nurses' notes can be made on the portable unit.
 7. Used or unsterile equipment *remains* on portable unit.
 8. Check equipment before returning to service department.

Diabetic Coma Treatment Stand Equipment:

Insulin:

- 4—10 cc. vials of regular insulin (U 40).
- 4—10 cc. vials of crystalline zinc insulin (U 40).



Fig. 1



Fig. 2

Insulin Syringes:

2—BD insulin syringes—U 40 type—sterile (packages plainly marked).

Antiseptics: 70 per cent alcohol solution, with gauze, cotton, adhesive, and bandage scissors.

Examination Equipment:

Blood pressure apparatus (sphygmomanometer).
Flashlight and tongue blades.
Stethoscope.

Blood and Urine Collection Equipment:

1. Citrate bottle with 10 cc. sterile syringes and needles, etc., for blood sugar, CO₂ combining power, blood urea nitrogen, and blood lactic acid.
2. Urinal, urethral catheter (sterile), and lubricant provided for immediate check of urine.
3. Laboratory forms.

Solutions for Intravenous Therapy:

1. Isotonic normal saline—1000 cc. (3)
2. 5 per cent glucose in normal saline—1000 cc. (3)
3. Ringer's solution—1000 cc. (3)
4. 6 molar lactate—1000 cc. (3)
5. Soda bicarbonate—50 cc. ampule (3.75 gm.) (1)
6. Four 50 cc. ampules of 50 per cent glucose; two 50 cc. syringes (for hypoglycemic reaction).
7. Human plasma (dried)—500 cc. and equipment.

Intravenous Stands Available on All Floors

Urine Chemistry Equipment:

Laboratory equipment provided in portable unit for performing urine sugar (glucose) and acetone tests at the bedside every hour or every three to four hours as necessary. Test tubes and copper racks provided.

Clinitest Kit for urine sugar (read instructions; colors are similar to Benedict test):

5 drops of urine.

10 drops of water.

Add Clinitest tablet, and read result by color.

Acetone Reagents (3 bottles):

5 cc. of urine in test tube.

Add 5 drops of glacial acetic acid and 5 drops of sodium nitro-prusside.

Overlay carefully with ammonium hydroxide.

When positive, reddish-purple ring is present.

Galatest Acetone powder and filter paper for test:

Add 2 drops of urine to small part of powder.

Pinkish color denotes presence of acetone.

Diacetic Acid Test (Gerhardt):

To 3 cc. of urine, add ferric chloride 10 per cent drop by drop until phosphates are precipitated. Bordeaux red color develops with diacetic acid present.

Nurses' Charts for Diabetics:

1. 24-hour diabetic sheets.
2. Nurses' treatment sheets.
3. History and physical sheets.
4. Order sheets.
5. Biochemistry requisitions.

Medications for Cardiovascular support:

- | | |
|---|-----------------------------------|
| 1. Ampules of caffeine and sodium benzoate (7½ gr.) | } 2 cc.-10 c.c. syringes provided |
| 2. Aminophylline (intravenous), (gr. 3¾ and 7½) | |
| 3. Ephedrine sulfate (gr. ¾) | |
| 4. Adrenalin 1:1000 (1 cc. ampules) | |

Booklet for entering patient's name, age, hospital location, physician, and date admitted provided. The nurse in charge will enter above data in booklet before returning equipment.

TREATMENT OF DIABETIC COMA

(Excerpted from *J. A. M. A.*, Jan. 1, 1949, Treatment of Diabetes Mellitus, by Dr. Elliott P. Joslin, Boston, Mass.)

First Hour after Admission

Assign special nurse, experienced in coma treatment, for the first few hours.

Laboratory

1. *Urine*—examine for sugar, diacetic acid, albumin, coma cast, and pyuria. Catheterize if necessary.
2. *Blood*—test for sugar and carbon dioxide content, with emergency report inside the hour. White blood cell count and nonprotein nitrogen also of value.
3. *Search for complications*
 - A. History to explain cause of coma.



Fig. 3

B. Physical examination, noting particularly:

- (a) State of consciousness, type of respiration, pulse rate, blood pressure, and rectal temperature.
 - (b) Look for soft eyeballs, dry tongue, dilated stomach, cold and mottled skin, and impacted rectum.
4. *Insulin*—100 units of crystalline insulin subcutaneously at once for adults, if blood sugar exceeds 300 mg. per 100 cc. and if the blood carbon dioxide content is 9 millimols per liter (20 volumes per hundred) or less. The dose would be proportionately less in cases of recent onset of diabetes or in young children. In cases with blood sugar between 600 and 1000 mg., give 300 units additional. In patients in circulatory collapse, give preliminary additional doses of insulin intravenously.
5. *Gastric lavage*—use large tube, aspirate completely, and wash stomach with warm water with greatest care.
6. *Sodium chloride*—give 2000 cc. of isotonic sodium chloride solution intravenously and repeat if indicated by dehydration and blood pressure below 90 mm. of mercury. Avoid too rapid administration, especially in older patients.
7. *Warmth*—keep patient warm, yet avoid burns, as from hot water bottle.

Second to Sixth Hour

Occasionally the gravity of the condition necessitates repetition of first hour's total insulin in the second hour.

8. *Tests*—repeat blood sugar and carbon dioxide determinations after three hours. For rising blood sugar give insulin, 50 to 200 units, according to physician's judgment of prognosis.
9. *Fluids by mouth*—as soon as tolerated, give 100 to 120 cc. per hour of broth, ginger ale, orange juice, tea or coffee, to be sipped by patient or spooned by nurse. If nausea and vomiting recur, withhold fluids orally for twelve hours (lavage stomach again if indicated) and then resume.
10. *Soft food*—soft or liquid food such as oatmeal gruel, orange juice or milk diluted half and half with lime water, not to exceed 10 Gm. carbohydrate per hour.
11. *Enema*—for cleansing and to relieve abdominal distention.
12. *Blood pressure, pulse, and temperature*—record blood pressure, pulse, and temperature; note signs of improvement or the reverse.
13. *Urinalysis*—perform urinalysis for sugar and diacetic acid every hour. Record volumes.

Sixth to Twenty-fourth Hour

14. *Tests*—repeat blood sugar and carbon dioxide determinations and give insulin, 50 to 200 units, if blood sugar and carbon dioxide levels are not improving.

Insulin (crystalline) may be now given according

to results of urine tests every one to four hours if fall in blood sugar has been satisfactory.

Give ...	red	orange	yellow	green	blue
	20	16	12	0	0
	units				

15. *Urinary output*—observe this closely and note with alarm any sign of anuria. Treat with 1500 cc. of isotonic sodium chloride solution intravenously if shock is persisting. Repeat as necessary. For anuria, associated with hypochloremia, give 50 cc. of 10 per cent sodium chloride solution intravenously. Never give hypertonic dextrose solution to promote diuresis. Beware of producing excessive diuresis with consequent loss of base, especially of potassium.

Second Day

16. *Soft food*—diet: carbohydrate 100 to 150 Gm., protein 50 Gm., and fat 50 Gm.
17. *Protamine zinc insulin* should be given, supplemented by crystalline insulin in small to moderate doses before meals, as indicated by results of blood sugar and urine tests.

Third Day

18. *Diet*—patient should gradually return to the standard diabetic diet for age and weight with carbohydrate 150 to 200 Gm., protein 60 to 100 Gm., and fat 60 to 120 Gm. daily.

DIFFERENTIAL DIAGNOSIS OF COMA *

The most common causes of coma according to relative frequency are:

1. Alcoholism.
2. Trauma (head injuries—extradural or subdural hemorrhages).
3. Cerebrovascular lesions (cerebral hemorrhage and cerebral thrombosis and occasionally malaria).
4. Epilepsy.
5. Diabetic acidosis.
6. Meningitis (usually in epidemics of meningitis).
7. Pneumonia (toxemia).
8. Cardiac decompensation.
9. Exsanguination.
10. Hypoglycemia.
11. Uremia.
12. Eclampsia.
13. Poisons, such as barbiturates and carbon monoxide.
14. Hysteria.

1. *Alcoholism*

Findings: Odor to breath; hyperemia of face; neck, throat, and conjunctiva; low blood pressure. Fatal cases show cyanosis, enlarged heart, irregular heart sounds of poor quality, and pulmonary rales.

Respiration: Slow and stertorous

Pulse: Full, regular, and slow

Temperature: May be subnormal

Eye signs: Pupils dilated

* (Differential Diagnosis of Coma must be excluded from Albert: *Modern Management in Clinical Medicine*, 1946. The Williams & Wilkins Company, Baltimore.)

Other signs: May be delirious, but can be aroused.

Laboratory: High white blood count and non-protein nitrogen. Blood alcohol over 1 per cent.

2. Trauma (head injuries)

Findings: History or evidence of head injury. Bleeding from nose, mouth, or ears; skin is cold and clammy.

Respiration: Rapid and irregular, slowing to Cheyne-Stokes type.

Pulse: Rapid, later slow.

Temperature: Variable.

Eye signs: Usually inactive, sometimes unequal, photophobia.

Other signs: Absent reflexes, incontinence, and paralysis of cranial nerves.

Laboratory: Bloody spinal fluid with or without increased pressure.

3. Cerebrovascular Accidents

Findings: History of sudden onset; usually of advanced age; flushed, cyanotic face; head and eyes may be deviated to one side; increased blood pressure.

Respiration: Slow, deep, and stertorous.

Pulse: Slow and bounding.

Temperature: May be low-grade fever.

Eye signs: Normal, dilated, unequal, deviated, or inactive.

Other signs: Hemiplegia; loss of deep reflexes.

Laboratory: Bloody lumbar puncture with increased pressure.

4. Epilepsy

Findings: History of characteristic seizures, scars on tongue or head from previous falls; face congested.

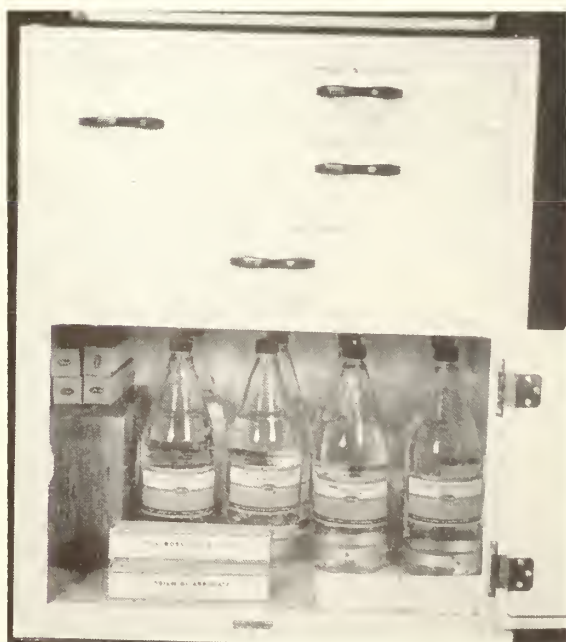


Fig. 4

Respiration: Slow.

Pulse: Normal.

Temperature: Normal or slight fever.

Eye signs: Fixed during convulsions.

Other signs: Limbs relaxed; evidence of involuntary defecation or micturition; tongue may be bitten.

Laboratory: None.

5. Diabetic Acidosis

Findings: History of indiscreet diet; omission of insulin; lips cherry red in color and face flushed.

Respiration: Kussmaul type of breathing—deep with signs of air hunger; fruity odor to breath.

Pulse: Increased.

Temperature: Subnormal.

Eye signs: Softened eyeballs; may be inactive.

Other signs: Cold, dry skin.

Laboratory: High blood sugar and decreased CO₂ combining power; sugar and acetone in urine.

6. Meningitis

Findings: Nuchal rigidity; positive Kernig and Brudzinski signs; may be in those under 10 years of age; bulging fontanels.

Respiration: Rapid.

Pulse: Rapid.

Temperature: Increased.

Eye signs: Variable.

Other signs: Increased intracranial pressure or signs of meningeal irritation.

Laboratory: Increased cell count, protein and chloride in spinal fluid; increased pressure; decreased sugar in spinal fluid.

7. Pneumonia

Findings: Fever—may have hyperpyrexia; history of chilliness or chill; pulmonary signs of dyspnea and cyanosis; physical signs of lobar or bronchopneumonia.

Respiration: Increased rate (30-60 per minute).

Pulse: Usually rapid.

Temperature: High fever usually.

Eye signs: Variable.

Other signs: Clinical picture of acute pulmonary infection, with overwhelming toxicity, and "toxic" meningeal or cerebral involvement.

Laboratory: X-ray evidence of consolidation in lung; possible bacteremia or septicemia with pneumonia.

8. Cardiac Decompensation

Findings: History of acute or chronic heart disease; sudden decompensation of cardiac function with resulting venous congestion and cerebral anoxia.

Respiration: Increased, with probable dyspnea and cyanosis.

Pulse: Rapid—may be irregular with fibrillation.

Temperature: Normal or subnormal.

Eye signs: As in syncopal attacks.

Other signs: May have pallor, shock, and other signs of cardiac failure.

Laboratory: Electrocardiographic findings.

9. Exsanguination

Findings: Extreme pallor and shock associated with blood loss, whether from laceration of major blood vessel or from bleeding duodenal ulcer, etc.

Respiration: Rapid.

Pulse: Rapid and thready.

Temperature: Subnormal.

Eye signs: As in syncope.

Other signs: Depending on cause and extent of blood loss.

10. Hypoglycemia

Findings: Moist, pale skin; history of overdose of insulin.

Respiration: Shallow.

Pulse: Normal or rapid.

Temperature: Normal

Eye signs: May be dilated.

Other signs: Deep reflexes exaggerated. Babinski sign may be positive.

Laboratory: Decreased blood sugar level, usually below 60 mg., in range of 60 to 30 mg.

11. Uremia

Findings: History of kidney trouble, hypertension, convulsions, or recent infection, pallor, twitchings, hiccough, enlarged heart, ammoniacal breath, increased blood pressure.

Respiration: Cheyne-Stokes type.

Pulse: Variable.

Temperature: Variable.

Eye signs: Hypertensive retinitis; may be inactive pupils.

Other signs: Edema of extremities and "uremic frost."

Laboratory: Albuminuria, cylindruria, and increased nonprotein nitrogen.

12. Eclamptic Coma

Findings: History of pregnancy; vomiting and convulsions.

Respiration: Variable.

Pulse: Rapid.

Temperature: Moderate fever.

Eye signs: Usually equal.

Other signs: Abdominal tumors, edema, increased blood pressure, and convulsions.

Laboratory: Abnormal urine; increased nonprotein nitrogen and uric acid.

13. Non-alcoholic Poisoning (such as barbiturates and carbon monoxide)

Findings: History important, odor of breath, cherry red color of skin in carbon monoxide poisoning.

Respiration: Variable.

Pulse: Rapid and weak.

Temperature: Moderate fever.

Eye signs: Dilated in carbon monoxide poisoning.

Other signs: Look for acid burns on oral mucosa.

Blood bright red in carbon monoxide poisoning.
Laboratory: Odor, appearance, and chemical analysis of stomach washings; carbon monoxide hemoglobin in the blood.

14. Hysteria

Findings: Coma not complete; eyelids flutter on painful stimuli; no injury suffered in falling.

Respiration: Normal.

Pulse: Normal.

Temperature: Normal.

Eye signs: Normal.

Other signs: Normal deep reflexes; bizarre neurologic findings as hemi-anesthesia or peculiar paralyses.

Laboratory: Not diagnostic.

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THE HISTORY OF MSSP

The long-promised history of medicine in Pennsylvania is now rapidly taking form.

The January *Journal* will contain a form by means of which your copy (\$4.50) may be ordered. Look for it.

Diagnostic and Therapeutic Problems in Large Bowel Obstruction Due to Carcinoma of the Colon

ALEX W. ULIN, M.D., PAUL J. GROTZINGER, M.D.,
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THE CLINICAL aspects of large bowel obstruction due to carcinoma are generally well known. Vomiting is uncommon, abdominal distention is essentially colonic, the history of altered bowel function is usually characteristic, and the diagnosis is often verified by a scout film of the abdomen.¹ However, this simple description requires qualification; one may encounter deviations from the accepted syndrome. Patients may present repeated vomiting, perhaps feculent in nature. Dehydration may be present. A scout film of the abdomen may reveal a varying amount of small intestinal distention.² These sick patients, especially if aged or foreign-born, give a poor or vague history; some have a scar of a previous abdominal operation. The frequent association of colicky pain completes a picture representative of small intestinal obstruction. This not only involves a more subtle diagnostic problem but introduces one of management.

Time does not permit discussion of the pathophysiology of the closed loop obstruction and the so-called ileocecal valve incompetence. Suffice it to say that our clinical and experimental observations^{3, 4, 5} have impressed us with the importance of small intestinal physiology in the pathogenesis of what we call the "tension closed colon loop." Simply, our thesis is that in large bowel obstruction the small intestine cannot be ignored diagnostically or therapeutically.

Of the 341 cases of carcinoma of the colon (Table I), 36 were partially obstructed and 33 were completely obstructed on admission to the hospital. The 69 cases analyzed were those in which acute large bowel obstruction presented

either a diagnostic or a therapeutic problem or both. In our series the sex distribution was about equal (Table II). However, in the 69 cases with acutely obstructed colons, 70 per cent were females. Of interest is the fact that 16 or 23 per cent of the obstructing lesions were located in the right colon (Table III). Exclusive of the cecum, about one-third of the lesions in the right colon produced obstruction. Of 24 lesions of the cecum, two produced obstruction as a result of an inflammatory process involving the terminal ileum. Consequently, it should be pointed out that tumors of the right colon often do produce obstruction.

Table IV demonstrates that our surgery was representative.

The findings suggestive of small intestinal obstruction that occurred in the 69 cases of acute large bowel obstruction are listed in Table V. The data indicate that the problem was prevalent in the partial as well as complete obstructions. It is noted that distention, vomiting, and colicky pain were common. It is true that these symptoms occur in a group of patients that represents from 10 per cent to at the most 20 per cent of the entire group of proved carcinomas. Although

TABLE I

CARCINOMA OF THE COLON—341 CASES

(Hahnemann Hospital, Philadelphia, 1945-1949)

Cases in which acute bowel obstruction was significant as a diagnostic or therapeutic problem.

	Cases	Male	Female
Partial obstruction	36 (10.6%)	11	25
Complete obstruction . .	33 (9.4%)	10	23
Total	69	21	48

Of 341 cases, 69 or 20 per cent presented the problem of obstruction.

Read before the Section on Surgery at the One Hundredth Annual Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 19, 1950.

From the Department of Surgery, Hahnemann Medical College and Hospital of Philadelphia.



Fig. 1

a small group, the over-all mortality is higher.⁶ These are usually the emergency admissions that often come in during the night and their diagnosis and management confront the younger physician and house staff. Of the 52 scout films, nine showed marked distention of the small intestine (Figs. 1, 2, and 3). In four of these cases there was no visible colonic distention detected and the x-ray diagnosis was small bowel obstruction. In one of these cases, after several hours of Wangenstein suction, the gastric and small intestinal distention were alleviated to such a degree that a repeat scout film now showed a distended cecum and evidence of acute large bowel obstruction.

Therefore, vomiting and colicky abdominal pain do not exclude the diagnosis of large bowel obstruction. The patient in the sixth decade of life or over, admitted to the hospital with the manifest picture of small intestinal obstruction, who has no hernia or history of previous abdom-

TABLE II				
CARCINOMA OF THE COLON—SEX DISTRIBUTION				
	<i>Male</i>	<i>Per Cent</i>	<i>Female</i>	<i>Per Cent</i>
341 cases	168	49.4	173	50.6
69 obstructed	21		48	
In the entire series	50.6 per cent were female			
Of the 69 obstructed cases ..	70 per cent were female			
OR				
Of all male cases ..	12.5 per cent presented obstruction			
Of all female cases ..	28 per cent presented obstruction			

TABLE III		
CARCINOMA OF COLON—SITE OF LESION IN RELATIONSHIP TO OBSTRUCTION		
Site of Lesion	Total No. of Tumors	Obstruction
Cecum	24	2
Ascending colon	26	10
Hepatic flexure	9	0
Transverse colon	16	4
Splenic flexure	16	8
Descending colon	15	10
Sigmoid	61	20
Rectosigmoid	53	10
Rectum	118	5
Anus	4	0
	342	69

inal surgery, should be suspected seriously of having large bowel obstruction.

In every case eventually a more or less typical history of change in bowel habit, bouts of distention, weight loss, and easy fatigability could be obtained. The anamnesis associated with intermittent diarrhea, melena, fever, and even chills may also indicate the possibility of malignancy. One should not too readily fall back to the diagnosis of colitis in the older patient. In our series, malignancy of the colon was nearly always associated with inflammation and spasm in the acutely obstructed cases. Colitis and pericolicitis were present, but the primary lesion was carcinoma.

Physical examination revealing hyperperistal-



Fig. 2



Fig. 3

sis and visible small bowel loops does not rule out large bowel obstruction. The patients with an associated picture of small intestinal distention presented dehydration and disturbance in fluid and electrolyte balance. However, fever and leukocytosis were not pronounced. A rapid pulse even after sedation was significant.

The examination should include rectal, pelvic, and sigmoidoscopic study. Whenever possible, the lesion should be biopsied. X-ray studies are indispensable. Scout films are usually diagnostic. The barium enema itself may produce complete obstruction. However, in questionable cases, it will clinch the diagnosis. Also, location of the lesion and the detection of multiple lesions are important in determining the type of surgical decompression to be done and in planning the definitive surgery. Patients suspected of having large bowel obstruction should not receive a barium meal for a gastro-intestinal study. Fig. 4 is an example of this error. This film was taken more than five days after the gastro-intestinal

series; the patient was an emergency transfer to this hospital with signs of complete large bowel obstruction.

The following questions arise in the treatment of these patients: Are conservative measures useful? Surgical decompression being the decision, should one do a transverse colostomy or a cecostomy? Conservative measures of decompression, even at best, afford no predictable success. Nearly always, however, this management, if calculated and judicious, will improve the patient. In our series only 4 cases out of 48 responded well. However, scrutiny of the charts reveals that in only 10 of the 48 cases were the conservative measures anywhere near adequate. The associated condition of small intestinal distention is the key for adequate treatment, and should include: no oral intake, efficient suction, parenteral alimentation, sedation, antispasmodics, oxygen, antibiotics, and judicious use of oil retention and salt and soda enemas. The details of this program should receive serious and competent attention.

Physiologically and pathologically, there is sound basis for attempting conservative decompression and treatment. Outside of the hospital it is not uncommon for a patient to be cured of his large bowel obstruction by emesis and enemas. Of the 69 obstructed cases, 18 gave a history of one to four previous episodes of complete obstruction relieved at home. Among the cases not obstructed on admission there were similar



Fig. 4

TABLE IV

CARCINOMA OF THE COLON—341 CASES
(Hahnemann Hospital, Philadelphia, 1945-1949)

	Cases	Per Cent	Deaths	Mortality
Operated upon ..	316	93	27	8.6%
Resected	261	76	12	4.6%
69 Obstructed Cases				
Resected	57	82.6	3	5.3%
All cases	69		8	11.7%

instances. Still, in practice, it is a mistake to stubbornly adhere to this treatment if results and progressive improvement are not soon evident. If the patient starts to pass flatus or feces or gives other evidence of satisfactory decompression, we defer surgical decompression. Within 24 hours, a decision may be made. Regardless of the result, the patient will be abdominally and generally in better condition for the emergency surgery. Also, in that time his diagnostic profile may be completed and there is less chance for error in the complete evaluation of the medical as well as surgical status.

We have found transverse colostomy, as advocated by Wangenstein, an excellent operation when the left colon is the site of obstruction. (Still, it may not be the operation for the surgeon who has only an occasional experience with colon surgery.) It has been taught that for decompression a cecostomy is adequate; for diversion of the fecal stream, colostomy is indicated. The corollary that with obstruction by carcinoma only cecostomy is required does not follow. Our observations indicate that usually acute obstruction is caused by acute pathologic changes that complicate the carcinoma (Table VI). Therefore, from this standpoint, complete diversion of the fecal stream would be best. Furthermore, with a hugely dilated touchy cecum, it might be safer to approach the transverse colon for decompression.

Our experience with transverse colostomy is limited to a small number of cases. We are trying to do more of them. However, in a really sick patient, we have in the past resorted to

TABLE VI
PATHOLOGY—CARCINOMA OF THE COLON—
69 OBSTRUCTED CASES

	36, partial	33, complete
Annular constricting lesion . . .	35	33
Necrosis, ulceration	11	11
Mucus-forming	3	1
Inflammation, edema, abscess .	13	16
Obturation obstruction, barium	3	5
Obturation obstruction, fruit pits	0	2

cecostomy. For the left colon that is obstructed inalterably, transverse colostomy should apply. However, many of these obstructions are relieved by enemas, apparently obturation being more common on the left side. Finally, transverse colostomy requires eventual closure. A well-done cecostomy also presents this possibility, but closure here is a simpler procedure.

Our experience with cecostomy has been satisfactory when properly done and well managed. To enumerate the advantages:

1. For decompression, a direct approach is made to the most proximal part of the colon; it applies for all obstructions, left or right colon.
2. A simple procedure in an anatomic area that is well known to the average surgeon.
3. It can be done under local or spinal anesthesia. It requires a relatively small incision and the cecum is easily accessible and can be walled off from the rest of peritoneal cavity.
4. Eventually it will not interfere with definitive resection.
5. It is a direct approach to the part of colon most vulnerable to perforation. If perforation has occurred, it can be handled by suction and drainage.

6. There is immediate decompression of the distended cecum and colon.

7. It may be used advantageously in preparation of the patient's colon for definitive surgery.

8. Eventually there is spontaneous closure; surgical closure, if required, is a simple procedure.

9. In our series, cecostomy couldn't be correlated with increased morbidity and mortality.

The technique of cecostomy requires attention to detail:

1. The patient receives adequate preparation as outlined above.
2. Local anesthesia may be used.
3. The position of the cecum should be ascertained on the flat film.

TABLE V

FACTORS SUGGESTIVE OF SMALL INTESTINAL
OBSTRUCTION IN 69 CASES OF ACUTE
LARGE BOWEL OBSTRUCTION

	36, partial	33, complete
Hyperperistalsis	6	10
Repeated vomiting (more than one time in 24 hours)	19	27
Feculent vomiting	1	8
Colicky pain	29	33
No bowel movements		
1 to 2 days	1	3
3 to 14 days	10	20
No flatus passed over 24 hours	2	8
Flat film taken	16	26
Small intestinal distention		
slight	2	1
moderate	2	7
marked	2	7

4. A right McBurney type muscle-splitting incision is used, about 10 cm. in length.

5. Gentle handling of the cecum is required, also careful walling off of the entire perimeter of the area to isolate it from the rest of the peritoneal cavity. Suction should be available. The cecum must be brought up and, if necessary, the lateral peritoneal reflection is incised. A huge cecum difficult to handle can be decompressed with suction on a No. 17 needle, and then trocar cannula. Rarely need one apply intestinal occlusive clamps to the cecum.

6. A purse-string suture with atraumatic needle and silk or catgut is used to control the hole of the needle puncture and then the insertion of a No. 40 soft rubber Pezzer catheter. This catheter is placed up into the ascending colon (about 5 cm. beyond the frenula of the ileocecal orifice). The distal 8 or 10 cm. of catheter which is thus placed into the large bowel should have additional holes in it so that the cecum and ascending colon have access to its lumen. A final purse-string suture of silk assures a watertight junction of catheter with cecum; also, this suture catches the wall of the catheter in two places and thus fixes it.

7. The wound is closed to leave a full 5 cm. open. The cecum should be brought above the level of the peritoneum. Iodoform packing is inserted down to the cecum and the wound is thus packed lightly and wide open. The catheter is securely fastened to the skin by a No. 32 wire suture.

The details of the satisfactory management of a cecostomy cannot be neglected. They include:

1. Continuous Wangenstein suction by Levine or Miller-Abbott type of tube.

2. Nothing by mouth. Parenteral alimentation.

3. Penicillin and streptomycin or aureomycin.

4. The Pezzer catheter is connected to a drainage bottle and irrigations are started immediately. We use 25 cc. of warm salt and sodium bicarbonate solution every four to six hours.

5. The use of enemas depends on the individual case. Usually a warm solution of physiologic saline and sodium bicarbonate, one pint twice a day, is used.

6. This regime is continued until the patient's abdomen is flat, he has peristalsis, and the cecostomy is working well; often the patient is passing flatus and fecal material per rectum.

7. In preparing the bowel for definitive sur-

gery, the colon can be advantageously irrigated through the cecostomy as well as the rectum; a chemotherapeutic or antibiotic agent of choice is given orally and also instilled into the cecum.

We have found in using a cecostomy, with attention to all details outlined, that ordinarily it takes about one to two days for signs of decompression to become manifest. It takes about four to six days for the decompression to be anywhere near complete. We start to prepare the bowel for definitive resection about six days before the scheduled day of operation. We find that from the time of cecostomy it takes at least 14 days to have the bowel well prepared for surgery. The preparation for definitive resection in a patient with a transverse colostomy takes no less time and careful attention to detail.

Summary

To summarize: Acute large bowel obstruction due to carcinoma is a surgical emergency; of the 69 obstructed cases, 58 per cent required emergency surgical decompression. However, this expedient may be delayed in most cases for complete medical and surgical diagnosis, as well as for supportive and decompressive treatment to improve the general and abdominal condition of the patient. Conservative therapy practiced with the same enthusiasm and attention to detail as surgery may obviate surgical decompression in some cases. In right colon lesions, the primary operation may be definitive resection; this is possible only if the patient has had adequate preparation. Transverse colostomy is theoretically and actually the most direct decompressive measure for unrelenting obstruction of the left colon due to carcinoma. (Fecal diversion is desirable because the acute obstruction, as we have observed, is not due to carcinoma alone, but is associated with carcinoma plus inflammation or abscess.) However, it should be noted that, in our experience, cecostomy was a good operation. Properly done and well managed, it is generally useful in most cases of large bowel obstruction due to carcinoma.

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EDITORIALS

ANOTHER UNKIND CUT

In the August *Atlantic Monthly* there appeared an article entitled "How Good Is Your Family Doctor?" It was written by Caleb H. Smith, M.D., a surgeon of Bradford, Pa. In this article appears the statement that, of thirty general practitioners Dr. Smith has known for a period of ten years, only five practice modern medicine; the other twenty-five make no attempt at diagnosis or rational therapy.

Needless to say, this blast at the general practitioner is picked up as a reflection on established medicine by every journal that feeds on and exaggerates whatever it can find to discredit the forces opposed to state medicine and the welfare state. For example, this article is reviewed in the September *Consumer*, which volunteers a follow-up entitled "What Is the Remedy? Public Health Experts Prescribe Group Practice," and the reader is urged to write to the American Public Health Association for all the answers.

Dr. Smith's chief complaint is that these twenty-five miscreant malpractitioners merely prescribe for the symptoms. He reads their minds sufficiently to know that they never give a thought to the cause of the complaints. He

makes a plea for diagnostic and therapeutic techniques which are certain to solve the illness.

The real answer to Dr. Smith can be abbreviated into the words, "He does not know what he is talking about."

Where will one find greater diagnostic genius than in the general practitioner who has to become so self-reliant? Where has experience built up a greater background of good common sense? Can the laboratory techniques elucidate cause in all the cases? Consider the neurotic or the psychosomatic with his intangible symptoms, but with perhaps a home situation or an anxiety—the "good old family doctor" can spot the condition and handle it accurately.

No one of our profession would minimize the help of many of the laboratory tests if properly and intelligently evaluated. But they are not infallible, nor do they always give either a diagnosis or solution. Your writer happens to be a specialist who has sat in at general staff meetings for years, and from the side lines, as it were, he has seen where the abstruse cases have often resolved themselves into no alternative other than to treat the symptom.

There can be no criticism of the general prac-

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the State of Pennsylvania

titioner who treats symptomatically his many patients with casual complaints. Certainly he is conscious that his local home-town reputation cannot stand bungling and mistakes, and he guards against these by referring his patient, when it is necessary, to where he can get a specialist's opinion. When all is said and done, the general practitioner is quite the best man for the "difficult case" to seek first. Here will be given a breadth of view which is rarely seen in the specialist.

John B. Deaver was rather annoyed with the term "specialist" and would not permit himself to be so classified; he said that "it took twelve specialists to make one doctor."

To avoid contrasts, comparisons, and criticisms further, we will miss dropping into that group of disgruntled, thwarted souls who invariably boost their own ego by belittling the other fellow. There is a place for all of us, and we hope that for years to come the general practitioner with his genius and common sense will still be with us.

Certainly it is regrettable that one of our number thoughtlessly gives aid, comfort, and argument to the forces we know to be heading down the wrong road.

DOUGLAS MACFARLAN, M.D.

WHAT'LL YOU HAVE—DOG TAG OR TATTOO MARK?

The Editor's desk dictionary defines the word "moot" as "intended for discussion or still open for discussion."

That the subject "mass blood typing" may be accurately described as a moot question, being widely discussed without much prospect of a crystallized solution, is obvious in the face of the following:

The Board of Trustees of The Medical Society of the State of Pennsylvania, in Philadelphia, in October, considered a resolution urging the Governor of the Commonwealth of Pennsylvania to recommend to his Director of Civilian Defense the immediate blood typing of every citizen in the Commonwealth, which blood typing shall be registered on a *dog tag* to be worn by every citizen at all times.

During the discussion in Philadelphia, it was said that the state school authorities were considering the blood typing, against the day of an

atomic disaster, of all school children and that some hospitals were similarly typing all newly born babies.

It remained, however, for the defense authorities of the city of Chicago to plan to blood-type all its population and to have the blood type stenciled on each person's left chest wall.

The American Medical Association, in October, declared blood typing of the general population "inadvisable for technical reasons" and its Committee on Blood Banks also said:

"Previous experiences in mass typing have been disturbing rather than reassuring," and also on the advice of Federal officials "stressed the importance of increasing the production of blood substitutes as well as whole blood in the present emergency."

In conclusion, we quote an individual expert who definitely condemns *mass* blood typing:

"Dr. Thomas H. Seldon, of Rochester, Minn., who is president of the American Association of Blood Banks, recently stated: 'I myself would not rely in a transfusion on a typing determined by someone completely unknown to me. Many blood banks will not accept the typing even of another blood bank. In case of mass disaster, volunteer donors could be typed in 10 minutes and so-called universal donors possessing type O blood could be used exclusively. The victims would not need to be typed if O blood were being given.'"

Leave it to the very nature of the threat (war-borne disaster) that precipitates this emergency discussion to revive the often repeated and never successfully refuted statement that "doctors often disagree."

ALL HAIL THE INTELLIGENT ELECTORATE!

There are valid reasons to believe, and dynamic election results to substantiate the opinion, that the influence of members of the healing arts profession on voters in Pennsylvania was effective at the polls in the election of Nov. 7, 1950.

Numerous commentators, familiar nation-wide to millions of radio listeners, were heard to give full credit to the doctors for their organized endeavors against national socialism. The same was said by widely read nationally known magazines and newspapers.

David Lawrence, well-known syndicated col-

mnist and editor of the weekly *U. S. News and World Report*, in his Nov. 9, 1950 column headed "Today in Washington," as it appeared in the New York *Herald Tribune*, in discussing causes of the November 7 general election results included the following:

"One more thing can be asserted in interpreting the results. The doctors got busy and fought the administration on its socialized medicine program. The farmers got busy and fought the Brannan plan. The day of the 'welfare state' in the sense of the 'hand-out state' is coming to an end as a political asset."

As a precautionary voice against overconfidence, settling down to indifference toward continued personal efforts against the "welfare state," we will join with many others in cautioning readers of medical publications to continue to support the profession's national and local educational program; to be on guard against threatening legislation in the Congress and state legislatures, and above all to remember that improved public relations begins with the individual doctor in his contacts with his own patients, friends, and neighbors.

OUR 102D ANNIVERSARY

We have read of the 1950 convention of The Medical Society of the State of Pennsylvania as having been "a delightful occasion" (*Philadelphia Medicine*), and in the *Pittsburgh Medical Bulletin*, as well as the *Northampton County Bulletin* and other bulletins, as having provoked the appended comments:

"... Probably the most important feature was the attendance of members at the scientific sessions, which were conducted, without interruption except for luncheon, each day—Monday through Thursday—from 9 a.m. until 5 p.m. This represents an increase of five hours, Monday, 10 a.m. to 5 p.m., over the programs prior to 1948.

"Also, by means of the 'study clubs' held Thursday afternoon, 1:30 to 5:00 p.m., the total attendance at scientific sessions during the last afternoon was increased this year to between 400 and 500, whereas in previous years Thursday afternoon's attendance ranged from 250 to 300. The 'study club' periods were declared a success and may become a fixture for future annual sessions.

"The House of Delegates, having less business to transact than usual, did not meet at all on Tuesday, thus giving the 153 delegates registered in the House a full day's opportunity for attendance on scientific sessions, as well as Wednesday afternoon and Thursday, inasmuch as the House adjourned finally at 12:30 p.m. on Wednesday.

"Registration. The registered attendance of members of the State Society was 2297, of which 974 were from counties exclusive of Philadelphia County (see registration by counties, page 1345); guest physicians registered, meaning non-members from Pennsylvania and other states, totaled 297; in addition, there were 383 hospital residents, 218 interns, and students of the Graduate School of the University of Pennsylvania which brought the total attendance of doctors of medicine to 3496. There were also medical students (senior class), nurses, Woman's Auxiliary members, exhibitors, and miscellaneous visitors, bringing the total registered attendance to 6017—a very satisfactory approach to the grand total registered during the centennial celebration in Philadelphia in 1948, which was 6228."

The program of the Religious Hour at 3:45 p.m. Sunday afternoon was conducted as printed in the September PENNSYLVANIA MEDICAL JOURNAL. The clergymen, the male chorus, and the magnificent organ in the Irvine Auditorium on the campus of the University of Pennsylvania, all served to satisfy and inspire the desires for worship of the several hundred men and women in attendance.

The annual State Dinner held in the Bellevue-Stratford Hotel, with 400 participants, was a happy occasion.

Dr. George F. Lull's well-organized address on "Medicine Looks Ahead" was well received and the postprandial entertainment—the dancing team, the splendid baritone, and the five lovely harpists—were all encored to the point of physical exhaustion. The 400 members and their ladies in attendance will doubtless look forward to next year's state dinner in Pittsburgh as will scores who enjoyed the entertainment features only from the ballroom balcony.

During the Installation Meeting on Tuesday night the stage was graced by the presence of thirteen former presidents of The Medical So-

ciety of the State of Pennsylvania in support of retiring President Samuel and incoming President Gardner (his acceptance address read immediately after his installation appears in the November issue of the JOURNAL.)

Dr. Gardner's next duty was to present the Benjamin Rush awards (see page 1099 of the October issue of the JOURNAL) and then to introduce Dr. Wallace M. Yater, of Washington, D. C., chief of the Department of Medicine, Georgetown University, who addressed those present of the 381 doctors of medicine who have completed the three-year course of the Graduate Education Institute of The Medical Society of the State of Pennsylvania. Engrossed certificates were presented to the graduates by Charles William Smith, M.D., chairman of the Commission on Graduate Education.

The detailed minutes of the Installation Meeting and list of the members of the Society who received certificates from the Commission on Graduate Education will appear in the next issue of the JOURNAL.

The President's Reception on Wednesday evening following numerous alumni association dinners was, as usual, the leading social affair of the week.

Those in the reception line were greeted by hundreds, and all later joined in the dancing either by personal participation or were vicariously highly entertained as onlookers from the balcony of the hotel ballroom.

NUTRITION IN CHRONIC DIARRHEA

(EDITOR'S NOTE: This is the eighth of a series of guest editorials furnished for the JOURNAL by members of the Commission on Nutrition of The Medical Society of the State of Pennsylvania.)

The term diarrhea implies abnormal frequency and fluidity of the intestinal evacuations. Chronic, therefore, is any diarrhea lasting more than a few days. With this in mind one must then consider all substances that will be lost to the body by too rapid passage through the digestive tract or by the action of various drugs.

Careful evaluation of clinical histories will reveal that the vast majority of patients have a marked tendency toward either hard constipated stools or soft semi-liquid stools. Confusion results in the lay mind concerning constipation and diarrhea and is often fostered by advertising statements and somewhat further confused by

medical advice that is uninformed. Chronic diarrhea, however, presents many problems of nutrition that are so insidious in their onset that they often escape clinical recognition.

One must first consider what has been taken into the body. A careful dietary history is therefore of prime concern. This history should cover the duration of the illness and not consist of a sample day's menu. Food and liquid intake should be estimated carefully and its adequacy balanced by the severity of the diarrhea. Several times the normal intake in the form of more concentrated food is, therefore, needed to balance the loss encountered.

Fluid intake must at least balance water output through respiratory, skin, urinary tract, and intestinal tract loss. The liquids needed, including water for a person of about 150 pounds in good health and under normal activity, amount to about 2500 cc. daily. This must be increased in chronic diarrhea and should be a minimum of 3000 to 4000 cc. a day. It should be remembered that protein in particular is laid down in the body with water, having a ratio of about 3 grams of water per gram of solid mass.

Food consumption is often a problem during prolonged gastro-intestinal illness. The importance of visual appeal in addition to taste appeal cannot be overemphasized. Quality of food, within the habits of the patient, is more important than quantity. The amount of food offered the patient at each meal and the amount consumed are widely apart. Only a constant check of food consumed will keep the physician informed as to adequate or faulty intake.

A negative nitrogen balance is present in most cases of chronic diarrhea because of the nitrogen loss in the stools and the failure of protein absorption. The normal male of 150 pounds in sedentary to active physical work requires 2400 to 3000 calories a day, of which at least 70 grams should be biologically potent protein. The level of protein intake necessary to obtain a positive nitrogen balance in chronic diarrhea represents from a 50 to 100 per cent increase in this amount or 105 to 140 grams of protein. Animal protein—meat or lactalbumin protein such as cottage cheese—is without doubt one of the best sources of this extra protein.

Carbohydrate, furnishing bulk for appetite satiation and calories for energy, is of somewhat lesser importance because most patients with even the worst eating habits will manage to obtain the necessary 1200 to 1800 calories of carbo-

hydrate in their diet. This may be less than ideal for a fairly long period of time without producing great and harmful changes in organ structures or functions. Glycogen liver depletion will occur and sometimes fat deposition in the liver will increase enormously.

Fat, normally consumed in 500 to 1000 calorie daily quantities, is too often reduced beyond reasonable limits. A good source of calories and in some forms handled with ease by the gastro-intestinal tract, fats are often stopped in the invalid's diet. In some pancreatic diseases and a few gallbladder and liver conditions where fat absorption or digestion is interfered with by the disease process, a temporary lowered intake may be indicated. This is seldom needed during any case of chronic diarrhea for a prolonged period of time. Parenteral use of fat emulsions is in the advanced experimental stage and will soon be available for general use.

The principal mineral substances lost by diarrhea are calcium and potassium. Daily requirements of calcium are about 1 gram a day on the average, but vary more widely than other minerals. Digestive tract mucosa and gland excretion and reabsorption are both impaired in chronic cases of diarrhea, so that normal levels of intake must often be raised five to ten times. Serum levels and evidence of bone absorption are important in regulating the intake of calcium.

Potassium has been more recently recognized as a mineral with a high rate of loss in diarrhea. Meat and its extracts is an excellent replacement substance. Broths and purée of beef contain large amounts of potassium. Some other less commonly used foods such as molasses, lentils, and nuts also contain large amounts of this mineral.

Other mineral substances such as iodine, iron, sodium, phosphorus, copper, sulfur, and magnesium are either needed in such small trace quantities or are so plentiful in all foods that recognizable deficiencies are not seen as a result of chronic diarrhea.

Vitamin substances are often deficient both for reason of inadequate intake and deficient absorption. Generally the deficiency is multiple and should be corrected by the use of multiple vitamins rather than the single ones. Many therapeutic agents, such as kaolin, adsorb dietary thiamine, thus removing it from possible utilization. Antacids, universally used in peptic ulcer disease, will absorb thiamine and probably several other of the more unstable B complex group.

Some of our daily requirements of vitamins are supplied by the action of the so-called "good" bacteria on foodstuffs. It should be pointed out that gastro-intestinal "antiseptics" such as the insoluble sulfa drugs and some antibiotics such as oral streptomycin, aureomycin, and terramycin change the intestinal flora radically and may, with prolonged use, result in deficiencies of the B complex group and probably also vitamin K with resulting change in prothrombin levels.

Vitamin C, of course, is so necessary for many functions and so harmless in large quantities that its liberal use in diarrhea is advocated. Necessary for iron absorption, needed for metabolizing glucose, related to oxidative degradation of some amino acids, vital for synthesis of adrenal hormones, and an intimate associate of oxidizing and hydrolytic enzymes, its importance cannot be overemphasized. In normal individuals the National Research Council has recommended a daily intake of 75 mg. of ascorbic acid. In chronic diarrhea this intake should be five to ten times this level or range from 300 to 1000 mg. per day. Excessive amounts are apparently excreted daily without harmful effect. Tests of capillary fragility done frequently will give fairly accurate information on the absorption effect of vitamin C.

Vitamin A and vitamin D, the fat-soluble substances, have not been reported as deficient from chronic cases of diarrhea. Changes in the mucous membranes should, of course, be suspect and moderate amounts of these vitamins given. Vitamin D poisoning has been frequently reported and, therefore, overdosage is to be avoided.

Sprue as a cause of chronic diarrhea is often overlooked because of its comparative rarity and lack of outstanding diagnostic findings. Folic acid and B₁₂ have been reported as curative for this condition. The clinical response is usually so rapid that in a few days normal stools occur so that prolonged use of folic acid is not indicated in the case that fails to respond quickly.

An acidity and hypo-acidity are little understood but definite causes of diarrhea. Absorption of both vitamin C and iron is deficient when acid is absent. Protein split is hindered and, therefore, less absorption occurs. Correction by the addition of dilute hydrochloric acid with meals or acid-producing capsules will quickly change the picture. Many chronic gallbladder infections with diarrhea will fall in this group

and will be greatly benefited by additional acid intake.

It should be pointed out that the so-called "neurogenic diarrhea" which is so prevalent appears to interfere very little with nutrition. In fact, it might be said that a long-standing diarrhea without clinical deficiency is a differential diagnostic point in favor of functional origin. Absorption of the nutrient necessities goes on in spite of the rapid passage through the intestinal tract. Sometimes these patients are good eaters and must compensate by a more than adequate intake.

The normal diet in health must be carefully regulated and adjusted in sickness. Latent deficiencies are often brought out by the stress of illness. Compensation by over-intake is the only satisfactory hope of correcting the imbalance and supplying needed protection for infection and wasting.

The oral route is first, last, and always the choice and should be carefully and thoroughly explored before parenteral fluids are given. It has been well said that we are the result of what we have eaten. Too much is as harmful as too little.

PAUL L. SHALLENBERGER, M.D.

AMA TIE-IN ADVERTISING CAMPAIGN A TWO-TO-ONE SUCCESS

Dr. Edward J. McCormick, of Toledo, a member of the Board of Trustees of the American Medical Association, in the following statement sets forth that Oscar R. Ewing, the Federal Security Administrator, on October 30 insulted the intelligence and integrity of millions of Americans in a speech before the Toledo Central Labor Union:

"The medical profession's nationwide advertising program earlier this month marked the first time in the history of the United States that a profession, business, or industry under Government attack has been successful in rallying nationwide advertising support from thousands of unrelated groups, companies, and individuals who also believe in freedom and preservation of the American way of life.

"That support, endorsing medicine's fight against socialization and reaffirming faith in the American system of free enterprise, came not from big business but almost entirely from small advertisers up and down the main streets and the neighborhood shopping districts of America. It came mainly from drug stores, groceries, dairies, hardware stores, insurance agents, small banks, dry goods stores, auto dealers, and many other types of small business and industry.

"Yet Mr. Ewing, speaking tonight before the Toledo Central Labor Union, and demonstrating his usual lack of respect for facts, truth, and the right of the American people to think for themselves, completely distorted the motives, methods, and results of the American Medical Association advertising program.

"He charged, among other things, that the AMA begged 'every other reactionary interest in the country' to join in and spend millions in the advertising campaign. He also said that the AMA is in league with 'every other reactionary group in the United States' in 'a conspiracy' and 'a sleazy plot' to wipe out American progress. And he reported that the AMA advertising campaign had turned out to be 'a complete flop.'

"Does Mr. Ewing class as 'reactionary interests' all those thousands of merchants, businessmen, professional people, and other small advertisers who voluntarily

bought advertising space to express themselves on the issue of freedom versus compulsion?

"Does Mr. Ewing attach the label of 'reactionary group' to the 10,000 public, civic, business, and professional organizations in America which during the past two years have gone officially on record against national compulsory health insurance or any other form of socialized medicine?

"Does Mr. Ewing dare to insinuate that such groups as the General Federation of Women's Clubs, the American Legion, the American Farm Bureau Federation, the Catholic and Protestant Hospital Associations, the American Dental Association, the American Bar Association, and 10,000 others like them are 'conspirators' in 'a sleazy plot to wipe out American progress'?

"Finally, how could Mr. Ewing know whether the AMA advertising program was a success or failure, when the results still are being tabulated? Is he trying to detract attention from his previous false claim that \$20 million would be spent by the AMA and the tie-in advertisers? Or did he and his cohorts purposely dream up that fallacious figure so that the program later would appear to have failed?

"Actually, a preliminary check of about half the country's newspapers indicates that final tabulations will show between 40,000 and 50,000 tie-in advertisers using double the amount of space purchased by the AMA itself. The AMA advertising budget was \$1,110,000, and it appears that tie-in advertisers spent about twice that much. The stated campaign objective was to achieve tie-in support matching the AMA space and expenditure. A two-to-one success can hardly be termed 'a complete flop.'

"Mr. Ewing apparently has lost all political restraint and all sense of intellectual decency in his frantic, frustrated efforts to play politics with the health of the American people. He now maligns not only the medical profession but also all Americans who choose to agree with the medical profession.

"His psychotic distortions, inaccuracies, and accusations are an insult to the intelligence and integrity of all Americans who believe in freedom of speech and fair play."

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Evidence of Progress in Cancer Control

Recent studies by the Division of Cancer Control of the Pennsylvania Department of Health, based on reports of the Bureau of Vital Statistics, would seem to indicate that a turning point may have been reached in the upward trend of annual deaths and death rates from cancer which has been going on for over forty years in this Commonwealth.

In 1906 the annual number of deaths from cancer in Pennsylvania was 4208 with a death rate of 58.9 per 100,000 estimated population. For subsequent decades, to and including 1946, the number of such deaths and death rates increased fairly constantly, as follows:

<i>Year</i>	<i>Deaths</i>	<i>Rates*</i>
1916	6,526	78.3
1926	9,172	98.6
1936	12,047	122.9
1946	14,776	144.4

The most up-to-date annual figures since 1946 show:

<i>Year</i>	<i>Deaths</i>	<i>Rates*</i>
1947	14,995	145.8
1948	15,668	149.3
1949	14,787	140.9

While it is too early to draw any definite conclusions, the ray of hope may be expressed that the high point or peak in the number of cancer deaths and death rates may have been reached in Pennsylvania in the year 1948. Even though some further temporary increases later may be noted in 1950 and subsequent years, evidence points to the suggestion that this great enemy of our citizens at least may be weakening and making its last stand against the united attack of all those forces fighting the disease.

Finally, it may be stated that such evidence of possible progress in cancer control in Pennsylvania should stimulate an ever-increasing program of activities to conquer the disease, with no letup of: (1) cancer education for professional

and lay groups; (2) statistical studies based on better reporting of cases by physicians and hospitals; (3) fundamental scientific research on the cause and possible cure of cancer; (4) promotion and operation of hospital tumor clinics for consultation, diagnosis, and treatment; (5) cancer detection services in doctors' offices or special clinics for apparently well persons; (6) much needed services to indigent cancer patients in the Commonwealth; and (7) further appropriation of funds for cancer control work.

The ultimate objectives at present should be early diagnosis and prompt and adequate treatment. Cancer, when diagnosed and properly treated in its earliest stage, now may be looked upon as a curable disease. The saddest words in the physician's vocabulary are the words "too late"! A good slogan in cancer control for every individual of this Commonwealth is: "I will go to my doctor before he has to come to me!"—LEVERETT D. BRISTOL, M.D., Chief, Division of Cancer Control, Pennsylvania Department of Health.

Pamphlets Available

The American Cancer Society, in cooperation with the National Cancer Institute of the U. S. Public Health Service, has prepared six "site" pamphlets to alert people to the dangers of a specific type of cancer.

Patients being treated for other diseases often ask questions about cancer. The pamphlets, therefore, fulfill a definite need in clinics, hospitals, health centers, and in the hands of doctors and nurses in private practice.

The pamphlets are "Cancer of the Skin," "Cancer of the Genito-urinary Tract," "Cancer of the Female Generative Organs," "Cancer of the Mouth and Respiratory Tract," "Cancer of the Digestive Tract," and "Cancer of the Breast." They can be obtained through community units of the Pennsylvania Division.

* Per 100,000 estimated population.

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Minutes of the One Hundredth Annual Session

Philadelphia, October 16-19, 1950

MINUTES OF THE HOUSE OF DELEGATES

Monday Morning, Oct. 16, 1950

The first session of the House of Delegates of The Medical Society of the State of Pennsylvania at its one hundredth annual session convened in the Clover Room, Bellevue-Stratford Hotel, Philadelphia, at 10 a.m., with the speaker, Dr. Lewis T. Buckman, presiding.

SPEAKER BUCKMAN: The House will please come to order.

The Chair recognizes Dr. Wilson, chairman of the Committee on Credentials.

DR. FRED B. WILSON (Beaver): There is a quorum present.

SPEAKER BUCKMAN: We are convening the one hundredth annual session of the House of Delegates of The Medical Society of the State of Pennsylvania.

You have in your copy of the Transactions a proposed order of business. If there be no objection from the floor, we will follow that order.

If there be no objection from the floor, we will dispense with the roll call at this meeting.

The minutes of the 1949 session of the House of Delegates were printed in the December, 1949, issue of the *PENNSYLVANIA MEDICAL JOURNAL*. Are there any corrections or additions to those minutes as printed? If not, they stand approved by action of this House.

Next is the report of the retiring president, Dr. E. Roger Samuel.

PRESIDENT E. ROGER SAMUEL: Mr. Speaker, Members of the House of Delegates: Before giving you my report, I want to thank the doctors of Pennsylvania for making this a splendid year for me and the House of Delegates for making this a splendid year for the physicians of Pennsylvania. We have had some controversies, some differences, and some things to do this year that we never had to do before, which is natural, but I think we have come through in fine style.

The Medical Society of the State of Pennsylvania is in a flourishing condition. Nearly all of the committees have functioned well. The trustees and councilors have given a tremendous amount of time to their work. As trustees, they have worked hard, but they have not been able to devote a lot of time as councilors. Some of the county societies have not been visited by the councilors and in only a few of the counties have the councilors had time to sit in conference with the officers and chairmen of important committees. Now that the annual councilor district meetings are about to be eliminated, I suggest that each councilor hold a councilor commission meeting in his district each year to which

will be invited the officers and committee chairmen of the county societies composing that councilor district. I found that very effective during my term as trustee and councilor. We met once a year to discuss the subjects that were necessary before we came into the House of Delegates.

The Graduate Education Commission is going ahead with its splendid task, but it may be necessary to curtail some of the activities if a large number of potential students are called into service.

The Procurement and Assignment Committee, with Dr. M. C. Stayer, of Cumberland County, as chairman, has already gone to work on a difficult job. This committee follows the general rules laid down by the State Society, the American Medical Association, and the government.

The Public Relations Committee has spent a lot of time and money this year and I believe that it is the finest committee in the country. It will continue to co-operate with the AMA. Too many doctors believe themselves too busy in their practice to lend a hand toward civic activities in their own community.

One of the best aids to the development of good public relations has been the establishment of an emergency medical call service by many of our county medical societies.

This will be a busy year for the Committee on Public Health Legislation, as there will doubtless be several controversial health bills introduced into the Pennsylvania Legislature during the coming winter.

The Government tells us that there are 16,000 doctors in Pennsylvania. On that basis, the allotments are made in the draft of physicians. Our society membership fluctuates between 10,000 and 11,000. I suggest that a committee of the House be appointed to look into these figures. I know that of the 5000 non-members some are undesirable, some have retired, some are teaching and doing research work, and many are serving as residents and interns in hospitals, but if we are to carry the ball for 16,000 physicians we ought to have every desirable practicing physician with us.

I notice that quite a few medical journals carry a president's page. Our auxiliary does. I suggest such a page to our Journal's publication committee.

We want to thank the Woman's Auxiliary for their great help in our public relations and legislative endeavors. In recent years they have been represented at the Secretaries Editors Conference, and I hope this practice is continued.

Thirty-four states have a grievance committee to hear the complaints of the public. The proposed change in our By-laws will permit us to hear such complaints without setting up a new committee.

I want to thank all of those who have made my year a pleasure, for without the help of the officers and office personnel your president would be almost helpless.

I want to take these last few minutes to thank this House of Delegates for the effort they put forth year after year in advancing the art and science of medicine, and for the time spent in not only work—diligent work—but in the social side that I think is so important for doctors. There is no finer group of men in the world than the doctors of Pennsylvania. I have found that out in the last two years, both as your president-elect and as your president. I have covered most of the State and it has been my pleasure to meet the finest group of men that it is possible for any man to meet. Thank you very much.

SPEAKER BUCKMAN: The remarks of President Samuel are referred to the Reference Committee on Reports of Officers.

The Chair recognizes Secretary Donaldson for our annual report, *In Memoriam*. I will ask the members of the House to rise.

In Memoriam

Members of the House of Delegates of The Medical Society of the State of Pennsylvania who have passed away since the 1949 session of the House (the years following each name indicate the years they served in the House):

ALLEGHENY COUNTY: Edmund C. Boots, 1945; James C. Fleming, 1941, 1943-48; Samuel R. Haythorn, 1942.

ARMSTRONG COUNTY: John S. McCafferty, 1935.

BLAIR COUNTY: Joseph D. Findley, 1930, 1933-35, 1937-41; George R. Good, 1943.

BUTLER COUNTY: Robert B. Greer, 1938.

CUMBERLAND COUNTY: Newton W. Hershner, 1936-45, 1947-49 (13 years).

FAYETTE COUNTY: Lewis M. Reichard, 1936.

GREENE COUNTY: Harry C. Scott, 1930.

LACKAWANNA COUNTY: James D. Lewis, 1930-34, 1936-40 (10 years).

LAWRENCE COUNTY: Samuel W. Perry, 1933, 1935.

LUZERNE COUNTY: Stanley L. Freeman, 1943.

LYCOMING COUNTY: Frederic C. Lechner, 1936, 1940.

McKEAN COUNTY: Samuel R. Huff, 1942.

MERCER COUNTY: Patrick E. Biggins, 1932-33.

MONROE COUNTY: Walter L. Angle, 1936, 1938.

PHILADELPHIA COUNTY: Andrew Callahan, 1930-31, 1938; Sigmund S. Greenbaum, 1933; Henry D. Jump, 1922-23, 1929.

SCHUYLKILL COUNTY: Christian Gruhler, 1928, 1932-35, 1937-38, 1940-42.

TIOGA COUNTY: William Bache, Jr., 1940.

WAYNE-PIKE COUNTY: Arno C. Voigt, 1930, 1937.

WESTMORELAND COUNTY: Russell A. Garman, 1942, 1947.

WYOMING COUNTY: Van C. Decker, 1936-38.

SPEAKER BUCKMAN: The House will be seated.

We have printed in the Transactions the list of reports which have been referred to the several reference committees. It does not seem necessary to read those.

The Chair will appoint:

Tellers—Drs. Norman C. Ochsenhirt, Allegheny County; D. Sergeant Pepper, Philadelphia County; Robert L. Schaeffer, Lehigh County.

Sergeants-at-arms—Drs. William J. Coreoran, Lackawanna County; Roy Deck, Lancaster County.

There have been prepared for distribution a number of supplemental reports. These were available in the rear of the room and doubtless each one of you have copies.

First is the supplemental report of the Committee on Public Health Legislation. Dr. Palmer!

DR. C. L. PALMER (Allegheny): Mr. Speaker, as you announced, copies of the report are available here, and I shall not take the time to discuss it. I will be glad to appear before whatever committee it is referred to and discuss recommendations that are contained therein.

Supplemental Report of Committee on Public Health Legislation

To the President and House of Delegates:

1. *Acknowledging support given us by legislators and congressmen:* During the past year, two of our state legislators received appropriate certificates, written and framed, commending them for their support of good public health and medical care legislation.

They were Dr. Leroy E. Chapman, Warren, a member of the State Senate, and Dr. George J. Sarraf, Pittsburgh, a member of the State House of Representatives. Presentation was made at their respective councilor district meetings.

In the opinion of the committee, this is an appropriate way to acknowledge their legislative activities.

2. *Replies from county medical societies to questionnaires:* Three requests for information have gone to county medical societies this year:

(1) Request to 23 counties composed of more than one legislative district for (a) number of doctors in each district, (b) number of registered voters, and (c) boundaries of each legislative district.

We received replies from all counties except Berks, Fayette, Lackawanna, Northumberland, Philadelphia, and Westmoreland. This indicates a good percentage; however, it is necessary that we have replies from all counties.

(2) Request for number of doctors and voting-age members of their families registered. If these figures were in our possession, they would give us an estimate of the possible voting strength of The Medical Society of the State of Pennsylvania.

Although this request was mailed September 25, to date we have received replies from but 20 counties. The percentage of accuracy of the replies ranges from 4 to 100 per cent with most being less than 50 per cent accurate due to the

fact that few of the societies had received replies from their entire membership.

This indicates a marked lack of cooperation on the part of a large number of county medical societies, and particularly a small percentage of replies from the individual doctors.

If members of the medical profession expect to assume their responsibility as citizens, there should be an effort to have 100 per cent registration and voting on the part of the membership. There must be an intense and persistent campaign year in and year out to obtain this result.

- (3) Each county medical society legislative chairman was requested to interview all candidates in his county and have them complete a questionnaire indicating their attitude concerning the following questions:

Maintaining a high standard of education for all practicing any form of the healing art.

Securing, through legislation, licensure or increase of scope of activity by persons practicing any form of the healing art, thus disregarding education and the high standard now maintained by the medical profession. This refers in most instances to chiropractors and naturopaths.

Increasing the appropriation for the Medical Care Program in the Department of Public Assistance.

Compulsory health insurance (socialized medicine) under any governmental agency.

Increasing the efficiency of the State Department of Health by an increased appropriation and security in their positions to its trained professional personnel.

Properly regulated animal experimentation assuring humane and sanitary procedures.

The committee is desirous of printing a pamphlet containing the attitude of all candidates in the November election to be distributed to the membership of the Society for their information in voting.

The fact that so many counties have not filled out and returned the questionnaires to your state committee shows a marked weakness. The committee desires to remind you that, if more cooperation is not obtained from county societies, our legislative program will not be very successful.

The committee therefore urges considerably more interest on the part of county societies in legislative activities so that better legislation can be secured in the interest of public health and medical care.

Detailed replies to all questionnaires are in the possession of your chairman and available on request.

3. Meetings with legislative committees from other organizations: This action was approved by the committee at its November meeting and by the Board of Trustees at its December meeting.

To date we have requested meetings with the associations composed of representatives from the county commissioners, boroughs, and first and second class

townships concerning the tentative bills drafted providing for local public health units and a system to provide security in their positions to the trained professional personnel in the Department of Health.

The committee intends to present our legislative program to labor groups, the Sportsman's League, parent-teacher associations, leaders of the House and Senate, and any other organization that it deems proper.

4. Future legislation: At present, bills have been drafted for presentation at the 1951 Session of the Pennsylvania Legislature, providing for the following:

- A. Local public health units.
- B. Security in their positions for the trained professional personnel.

(It was agreed by the committee that it will further explore the above two recommendations of the Keystones of Public Health to determine what bills will be most acceptable to those concerned and what attitude should be taken if bills are introduced in the next session of the Legislature. This is very apt to happen due to the publicity given the attitude of the Medical Society regarding these two particular items.)

- C. Deshocking program in hospitals (recommended by the Commission on Acute Appendicitis Mortality).
- D. Tax support for the medical care of certain indigent cancer patients (recommended by the Commission on Cancer).
- E. Regulation of sanitary conditions of trailer camps.
- F. Animal experimentation.
- G. Laboratory in the State Department of Health to assist rural coroners in cases of sudden death.

A bill providing for such a laboratory was passed in the last session of the Pennsylvania Legislature, but was vetoed by the Governor. It may be that it can be included as part of the recommendation of the State Department of Health Survey.

- H. Bills have been drafted providing for licensing chiropractors in three ways:

- (1) A bill defining chiropractic and providing that the Board of Medical Education and Licensure license them as they do now
- (2) An enabling act to accompany present Act 525 if it is maintained on the statute books.

This act defines chiropractic in a very limited way and will no doubt be bitterly contested by the chiropractors.

- (3) A bill providing for a composite board.

- I. Bills have been drafted to amend the Medical Practice Act concerning rebates for ophthalmologic, surgical, and other supplies.
- J. Bills have also been drafted providing for a Board of Examiners for psychologists and for licensing psychologists. This will be a rather controversial subject, but one that will have to be considered.

The committee has been requested to study the nurses' licensure bill.

The following recommendations for legislation from the Commission on Mental Hygiene were referred by the Board of Trustees to the Committee on Public Health Legislation:

- (1) Federal aid to mental hygiene clinics in Pennsylvania. This has been provided for by agreement between the Welfare Department and the United States Public Health Service.
- (2) Definition of some mental conditions in the aged.
- (3) Legislation for the segregation, care, and treatment of sex offenders.

The committee will again contact the Commission on Mental Hygiene to ascertain what ideas should be embodied in this legislation.

As usual, there will be many bills pertaining to public health legislation and medical care introduced into the Federal Congress and Pennsylvania Legislature when they convene in January. Their contents will not be known until they are introduced.

There will be the usual activity by limited licensees, such as chiropractors and osteopaths. The antivivisectionists will no doubt introduce a bill. There may be legislation introduced requiring compulsory immunization of all school children against diphtheria.

Consequently, the committee will have to meet many emergencies. We again request discretionary privileges to deal with these emergencies in consultation with the Board of Trustees, the committees concerned, and the House of Delegates, if necessary.

5. *Federal legislation:* One hundred and two House bills, 36 Senate bills, and 17 House and Senate resolutions were followed by the American Medical Association in Washington, and in turn by your Committee on Public Health Legislation.

Among the most important were the two reorganization plans, No. 1 and No. 27. Had these bills passed, the Federal Security Administrator would have obtained cabinet rank and been in a position to exert a great deal of influence on the passage of compulsory health insurance measures.

Through the efforts of your committee, county medical societies, and woman's auxiliaries, the great majority of our Congressmen voted against these measures, thus preventing the enactment of laws which would definitely affect the health and lives of our citizens.

The committee also, with the help of the county medical societies and woman's auxiliaries, was instrumental in obtaining passage of the Doctor Draft Bill. Bulletins concerning same have been sent to the county medical societies for their information.

6. *Requirements to carry out program* delegated to the Committee on Public Health Legislation. Due to the extensive state legislative program of The Medical Society of the State of Pennsylvania together with federal legislation and other activities of your chairman, which include chairmanship of the State Healing Arts Advisory Committee, Rural Medical Service, Advisory Committee to the Department of Vocational Education, Program Committee of the Pennsylvania Health Council, Inc., membership in the Conference of Licensees, and various other duties, it will be necessary for your chairman to spend most of his time at the Harrisburg office.

This will require two rooms, together with desks, filing cabinets, typewriter, etc. It will also be necessary to have proper secretarial service and legal services by the attorney for the committee.

Your chairman will do anything he can to further the interest of the State Medical Society while in Harrisburg.

7. *Election laws* were studied intensively by the committee, and bulletins were distributed to county medical societies calling attention to the important items in the election laws. Following are five important items:

- (1) Endorsement of any candidate by any state or county medical society is prohibited because this would mean some contribution or expenditure in advertising or printing which is not permitted.
- (2) Individual members of the state and county medical societies under the law may act individually using their own letterheads without receiving any subsidies from the state or county medical societies.
- (3) All publications, letters, bulletins, etc., must be signed by the proper committee chairmen or officers of the organization.
- (4) No anonymous communications are permissible.
- (5) Political action committees may be formed by individual members of the county or state medical societies and woman's auxiliaries together with members of other healing art professions. These committees must raise their contributions locally and keep records of all receipts and expenditures.

8. *The following articles* were written by your chairman and appeared in the PENNSYLVANIA MEDICAL JOURNAL:

"The Practice of Chiropractic in Pennsylvania"—February PMJ.

"Union Labor's Gratis Advice"—March PMJ.

"Pending Federal Health Legislation and Other Activities of the Committee on Public Health Legislation"—April PMJ.

"Fight Untruth with Truth" (Animal Experimentation)—PMJ.

"Formal Opinion Affects all Physicians in Pennsylvania"—(re prescriptions)—August PMJ.

9. *A memorial to Dr. Samuel G. Dixon*, the first Pennsylvania secretary of health, is still under discussion in the Department of Health and your chairman will cooperate with the department in having such a memorial approved and the location decided upon.

10. *Candidates for state-wide offices in November election:* In the presence of a witness, your chairman interviewed Mr. Richardson Dilworth, Democratic candidate for governor; Judge John S. Fine, Republican candidate for governor; Senator Francis J. Myers, Democratic candidate for the United States Senate; and has received a letter from Governor James H. Duff, Republican candidate for the United States Senate.

All declare they are absolutely opposed to compulsory health insurance and favor our legislative program.

Respectfully submitted,

C. L. PALMER, *Chairman*.

SPEAKER BUCKMAN: This report is referred to the Reference Committee on Standing Committees.

There is also a supplemental report from the State Healing Arts Advisory Committee. Dr. Palmer!

DR. PALMER: This report is brief, but it is very important.

Supplemental Report of State Healing Arts
Advisory Committee

To the President and House of Delegates:

We have been advised by Mr. Frank A. Robbins, Jr., Secretary of the Department of Public Assistance, that the department is very much concerned about controlling total expenditures for medical care and that there has been a steady increase in yearly costs per recipient. It is also difficult to determine the amount of treatment for which the department should pay in a specific case.

Because of the lack of funds and the increasing cost, the department has become very exacting in its payments of the invoices.

In correspondence with your representative, Mr. Robbins goes to considerable length describing the difficulties entailed in the present program. He requests that an experiment be made in counties willing to try a different form, in order to develop a more practical program so far as administration is concerned.

Several alternatives are suggested, but they favor paying a flat monthly amount to the physician for each of his patients who is an assistance recipient.

The department would pay a stipulated monthly amount to the physician for each recipient regardless of medical care provided. This amount would be based on the average monthly cost of medical care per recipient under the present program.

They claim this plan would eliminate sending invoices, itemizing each service, and verifying services rendered. No limits would be established or imposed on the practitioner. There would be no fee schedule, and no subordination of professional judgment to non-professional. Payment to the physicians would be more prompt and would average about the same over a period of time. The doctor-patient relationship would be preserved.

They claim there would be free choice of practitioner.

In the humble opinion of your representative, this would be a rather limited or select type of free choice of physician, and would eliminate services on a fee basis.

It would be somewhat of a reversion to the old contract system of practice. Since the medical profession is committed to a free choice of physician on a fee-for-service basis, the proper authorities of The Medical Society of the State of Pennsylvania should carefully consider whether or not they desire to experiment in any county desirous of experimenting along this line.

Mr. James Brindle, Director of Assistance, has indicated that a number of different plans are operating throughout the country. He mentions the Baltimore Plan, the Kansas Plan, the great variety of programs in New York State, and many local programs prevailing in other systems. He also emphasizes the difficulties of administering our plan.

I would suggest that the Committee on Medical Economics of The Medical Society of the State of Pennsylvania carefully study this question and report to the Board of Trustees at a later date. They should

determine whether or not the State Medical Society is willing to agree to experimentation of this kind.

Respectfully submitted,

C. L. PALMER.

SPEAKER BUCKMAN: This is referred to the Reference Committee on Reports of Commissions.

We have a supplemental report from the Committee on Emergency Disaster Medical Service. Dr. Fetter!

Supplemental Report of Committee on Emergency
Disaster Medical Service

To the President and House of Delegates:

In our previously submitted report, we stated that we hoped to present to the House of Delegates a full and concrete plan for the care and treatment of the sick and injured in the event of atomic bombings or other medical disasters. We are sorry to report that we are unable to do so at the present time due to a delay in the appointment of a director of the Medical Services and Evacuation Division of the Civil Defense program. Inasmuch as our program cannot be presented to any authorized individual for his approval, we cannot move forward with as much speed as the international situation may indicate. We should, however, like to report the following items:

On July 29, 1950, the chairman of our committee and officers of the Society attended a meeting of the Council on Emergency Disaster Medical Service of the American Medical Association held in the Statler Hotel, Washington, D. C. This meeting was primarily for the states on the eastern seaboard of the country and appropriate national organizations were represented. We are pleased to report that Pennsylvania is as far progressed in its Civil Defense program as any other eastern state. However, we do not believe that Pennsylvania is adequately prepared to meet any great emergency.

On Aug. 27, 1950, we recommended to the Board of Trustees that its chairman submit an appeal in writing to Maj. Gen. Richard K. Mellon, Director of Military and Civil Defense Commission for Pennsylvania. This letter in essence suggested to General Mellon that he appoint a director of Medical Services and Evacuation in order that the medical services in Pennsylvania may be prepared. We offered the cooperation of The Medical Society of the State of Pennsylvania and suggested that he call upon the Society to assist him in his gigantic task. No reply has been received from General Mellon. However, we do understand that he has reorganized his staff and has named a new director of the Civil Defense Program, Col. Alton C. Miller. We are continuing to cooperate with Col. Lewis F. Acker, assistant to Colonel Miller. However, we have not been called upon to render any specific suggestions in the last few weeks.

This committee has held one meeting since its formal report to the House of Delegates, at which time the new committee members were brought up to date on the above facts. It was also announced that Dr. E. Roger Samuel, president, appointed Dr. Charles Wm. Smith of Harrisburg as co-chairman. This was primarily indicated because it was found necessary to have someone in Harrisburg to reach immediate decisions on matters referred to the secretary.

We should like to report that a subcommittee on professional education is planning a program of education throughout the county medical societies and hospital staffs. Details of this plan will be reported to the Board of Trustees and an appropriate request for funds will be submitted. This, of course, is one portion of the program which we may move forward in because it depends primarily upon the physicians to educate the members of the profession in care and treatment of patients in the event of an atomic disaster.

The commission has approved the distribution of a questionnaire in cooperation with the Committee on Procurement and Assignment. The data received on this questionnaire will be placed upon IBM cards and be used primarily for the information of the Procurement and Assignment Committee. However, it will be available to our committee for purposes of arranging medical services in the event of an emergency.

One member of our committee, Dr. Frederic B. Davies, has prepared an article for publication in the JOURNAL entitled "Medicine Prepares for Atomic Disaster." Pre-copies of this article are being distributed to the county medical coordinators for their information and guidance. It is our hope that additional papers will be published in our JOURNAL which will be in the nature of professional education and will inform the membership of their responsibilities in the event of a disaster.

At the present time there are 37 counties which have named medical defense coordinators. We should like to ask the cooperation of this House of Delegates in requesting each county medical society to prepare itself by the appointment of a committee. The next few months should bring a final decision on the directorship of the medical services and evacuation program, and we believe that each county society should certainly have a committee prepared to assume these responsibilities.

Respectfully submitted,

THEODORE R. FETTER, *Chairman.*

DR. THEODORE R. FETTER (Philadelphia): Mr. Speaker, I would like, in connection with this supplemental report and our previous reports which were published from time to time in the JOURNAL and in various reports to the Board of Trustees, to present this resolution:

Resolution

WHEREAS, There is an accepted threat to American security; and

WHEREAS, At the national level this threat has been recognized sufficiently to create organizations dealing with civilian defense; and

WHEREAS, In the Commonwealth of Pennsylvania Major General Richard Mellon has been appointed to head up a civilian defense program for the Commonwealth; and

WHEREAS, One of the most important features of medical treatment against atomic warfare is whole blood in sufficient quantities that it is impossible for the Red Cross to furnish; and

WHEREAS, It is now accepted that every survivor becomes a potential donor; therefore, be it

Resolved, That The Medical Society of the State of Pennsylvania urge the Governor of the Commonwealth to recommend to his director of civilian defense the immediate blood-typing of every citizen in the Commonwealth, which blood type shall be registered on a dog tag to be worn by every citizen at all times.

SPEAKER BUCKMAN: This supplemental report, together with the resolution, is referred to the Reference Committee on Hospital Relations.

We have a supplemental report from the Commission on Physical Medicine and Rehabilitation. Dr. McKinsstry responded to the call for this report and advised that since each member of the House had a copy the reading should be dispensed with.

Supplemental Report of Commission on Physical Medicine and Rehabilitation

To the President and House of Delegates:

Survey Report. At the last meeting of the House of Delegates, this commission was delegated with the responsibility of conducting a survey of existing facilities in Pennsylvania for the care and rehabilitation of the severely handicapped. Upon careful investigation, we realized that a very comprehensive survey would cost the Society a minimum of \$35,000. However, in order that a limited survey could be completed, the Board of Trustees increased our budget several hundred dollars.

The method used to survey existing facilities in the hospitals throughout the Commonwealth and the statistics accumulated as a result may be found in the report distributed at this meeting.

In addition to this commission's survey, the Health and Welfare Council of Philadelphia surveyed Philadelphia, Delaware, and Montgomery counties. A complete report has been prepared on this latter survey, but the commission has not had sufficient time to consider its findings; therefore, no recommendations will be made in regard to those three counties.

From the statistics appearing in our report for the other counties in the State and the study which we have made of the problem, we wish to submit the following recommendations:

(1) That the minimum survey conducted by this commission be accepted and approved by the House of Delegates.

(2) That the House of Delegates recommend to all hospitals in the State of Pennsylvania that they assign a more adequate number of beds to the care of patients for rehabilitation purposes.

(3) That this commission be permitted to continue its study of the problem and be authorized to confer with the proper authorities of the Hospital Association, the Bureau of Vocational Rehabilitation, and the State Departments of Welfare and Health in order to encourage the establishment of more adequate beds for rehabilitation purposes.

Commission on Chronic Illness. The Board of Trustees referred to this commission the responsibility for coordinating the efforts of the State Society with the National Commission on Chronic Illness.

Although we recognize that this commission is concerned with the rehabilitation and care of many chronic cases of illness, we also realize that the field of chronic illness is not limited to physical medicine and rehabilitation.

It is our feeling that it should not be necessary to create a distinctly new commission on chronic illness at the present time and that this commission should continue the liaison which has already been established. However, we are of the opinion that, if and when a disease control committee is established, this problem

should be referred to it for discussion by the chairmen of all disease control commissions and committees.

Respectfully submitted,
ALBERT A. MARTUCCI, *Chairman.*

Summary of Survey of Rehabilitation Facilities in Hospitals in the Commonwealth of Pennsylvania, Excluding Philadelphia, Montgomery, and Delaware Counties

On April 21, 1950, a survey questionnaire was sent to 164 hospitals through the facilities of the Hospital Association of Pennsylvania. The questionnaire was arranged in four parts: (1) general information; (2) services available; (3) professional personnel; and (4) comments on other services or facilities. Therefore, this summary is divided into four parts.

General Information

A total of 100 hospitals responded to the questionnaire, and we find that 19 presently have physical medicine and/or rehabilitation departments. Fifteen of these were physical medicine departments, one was a department of rehabilitation, and three had both departments. Of the 19 hospitals having departments, 18 were in charge of a qualified physician. One of these was on a consultant basis.

The survey indicates that there are 316 hospital beds assigned to adults. However, in some cases, hospitals listed their complete capacity rather than only those beds assigned to physical medicine and rehabilitation. According to our best interpretation, we would estimate that 91 beds probably are assigned to rehabilitation and that 225 are doubtful and are assigned to other purposes. This same situation is true with the number of beds assigned to children. The survey indicates a total of 143 beds. Our interpretation placed doubt on 40 of these beds, leaving a total of 103 as possible beds assigned for rehabilitation purposes.

A total of 16 out-patient clinics were indicated. One of these clinics is in a hospital not having a department of rehabilitation or physical medicine. The other 15 are in hospitals with departments of physical medicine and rehabilitation.

Two additional hospitals indicated that they expect to have departments of physical medicine in new hospitals being presently constructed. Three hospitals indicated that, although they have no special rehabilitation departments, they are cooperating with the State Bureau of Rehabilitation and accept patients for care by private physicians with hospital privileges.

Services Available

Social Service. Twenty-one hospitals had social service available. Thirteen of these were with medical approval, six without medical approval, one with approval for private patients, and one hospital had the approval for the department, but had not established the service at the time of the survey.

Physical Therapy. Thirty-nine hospitals had physical therapy service. Thirty of these had medical approval, six were without medical approval, two departments have approval but have no service available at the present time, and one department indicated limited capacity.

Occupational Therapy. Eleven hospitals indicated occupational therapy services. Eight were with medical approval, two without medical approval. In one hospital the service was approved, but no services have been instituted up to the present time.

Psychologic Testing. Four hospitals indicated psychologic testing services. Two of these were with medical approval and two without medical approval.

Speech Therapy. Five hospitals indicated units of speech therapy, two of these functioning with medical approval and one without medical approval. Another has received approval for the service, but has not as yet instituted the actual program. One hospital furnished lip reading services without medical approval.

Vocational Counseling. Two hospitals indicated services of vocational counseling, one of these with medical approval and one without medical approval.

Educational Services. Six hospitals indicated educational services, four of these with medical approval and two without medical approval.

Patients' Library. Thirty-four hospitals indicated that patients' libraries were available. Eight were functioning with medical approval, 25 without medical approval, and one was defined as a traveling library.

Professional Personnel

Full-time paid personnel

Social service workers	37
Physical therapists	62
Occupational therapists	16

Part-time paid personnel

Social service workers	5
Physical therapists	17
Occupational therapists	1

Members of American Association of Medical Social Work	18
Graduates of a recognized school of social work ..	15
Registered in the American Register of Physical Therapy	33
Members of the American Physical Therapy Association	32
Graduates of an accredited school of occupational therapy	7
Registered occupational therapists	6

Comments

Nine hospitals indicated that at the present time they hire social service workers, physical therapists, and occupational therapists with varying degrees of experience and education. These are not included in the preceding figures.

SPEAKER BLACKMAN: This report is referred to the Reference Committee on Reports of Commissions.

A supplemental report has been received from the Committee on Public Relations.

Dr. Mayhew announced that the report had been distributed.

Supplemental Report of Committee on Public Relations

To the President and the House of Delegates

Inasmuch as a portion of the American Medical Association dues paid by Pennsylvania physicians has been

ing used to finance a national advertising program, your Committee on Public Relations feels obligated to report to you on the plans and progress of this campaign.

By the time you read this report, many of you will have already seen the advertisement as it appeared in the October 11 issue of your local papers or heard the radio spot announcements as they are currently being broadcast throughout Pennsylvania.

Perhaps you are wondering what the major objectives of this advertising campaign are. How broad is the coverage of this program? Is any of the AMA's advertising budget being spent in my home county? We trust that this supplemental report will answer these questions for you.

Major Objective

The major objective of the American Medical Association's newspaper, radio, and magazine advertising campaign is to rally all Americans in a nation-wide reaffirmation of faith in freedom.

Thousands of groups, businesses, and individuals are cooperating with the doctors in this campaign by subscribing to many thousands of dollars worth of tie-in advertisements to run concurrently with medicine's nation-wide advertising campaign.

How Broad Is the Coverage?

United States

- 11,000 daily and weekly newspapers
- 1,000 radio stations
- 112 Sunday magazine sections
- 39 state press association publications
- 21 national magazines
- 19 business publications

Pennsylvania

- 128 daily newspapers
- 334 weekly newspapers
- 75 radio stations
- 19 business publications
- 6 Sunday magazine sections
- 1 state press association publication
- 21 national magazines

What Is the Coverage in My County?

Newspapers—all bona fide paid circulation newspapers in Pennsylvania will carry the AMA advertisement.

Magazines

- "Time"
- "Life"
- "Cosmopolitan"
- "American"
- "American Home"
- "Ladies Home Journal"
- "Saturday Evening Post"
- "Woman's Home Companion"
- "Better Homes & Gardens"
- "American Legion"
- "National Amvet"
- "Collier's"
- "Newsweek"
- "Look"
- "Redbook"

- "Good Housekeeping"
- "Household"
- "Pathfinder"
- "McCall's"
- "Sunset"
- "Foreign Service"

Sunday Magazine Sections

- "The Philadelphia Bulletin"
- "The Pittsburgh Sun-Telegraph"
- "The Philadelphia Inquirer"
- "The Erie Dispatch"
- "The Harrisburg Patriot-News"

Radio

The appended report indicates the radio coverage in Pennsylvania.

Schedule

- Weekly newspapers Week of October 8, 1950
- Daily newspapers October 11, 1950
- Sunday supplements ...October 8, 1950
- National magazines
 - a. weeklies October 8, 1950
 - b. monthlies November, 1950 issue
- Radio Second and third weeks of October, 1950

AMA National Education Campaign

There are 95 radio stations operating in 45 counties in Pennsylvania. Seventy-five of these radio stations in 43 counties are scheduled to participate in the AMA's spot announcement advertising campaign.

Fourteen hundred and twenty-four spot announcements will be broadcast over these stations during the second and third weeks in October.

The following radio stations are to be used in Pennsylvania:

County	City	Station	Spots Per Week on Two-Week Basis	
			Day	Night
Allegheny	Pittsburgh	KQV	5	5
Allegheny	Pittsburgh	WCAE	5	5
Allegheny	Pittsburgh	KDKA	5	5
Allegheny	McKeesport	WMCK	7	7
Allegheny	Homestead	WHOD	4	4
Allegheny	Braddock	WLOA	4	4
Armstrong	Kittanning	WACB	4	4
Armstrong	Apollo	WVAL	4	4
Beaver	Rochester	WRYO	4	4
Beaver	Beaver Falls	WBVP	4	4
Berks	Reading	WRAW	5	5
Berks	Reading	WHUM	5	5
Blair	Altoona	WJAS	7	7
Blair	Altoona	WVAM	7	7
Bucks	Doylestown	WBUZ	4	4
Bucks	Morrisville	WBVO	4	4
Butler	Butler	WBUT	5	5
Butler	Butler	WISR	5	5
Cambria	Johnstown	WJAC	7	7
Cambria	Johnstown	WARD	7	7
Centre	State College	WMAJ	4	4
Chester	Coatesville	WCOJ	4	4

County	City	Station	Spots Per Week on Two-Week Basis	
			Day	Night
Clearfield	Clearfield	WCPC	4	4
Clearfield	Du Bois	WCED	4	4
Clinton	Lock Haven	WPBZ	4	4
Columbia	Bloomsburg	WLTR	4	4
Crawford	Meadville	WMGW	4	4
Cumberland	Lemoyne	WCMB	4	4
Cumberland	Carlisle	WLXW	4	4
Dauphin	Harrisburg	WKBO	3	3
Dauphin	Harrisburg	WHP	4	4
Dauphin	Harrisburg	WHGB	4	4
Delaware	Chester	WPWA	7	7
Erie	Erie	WIKK	5	5
Erie	Erie	WLEU	4	4
Erie	Erie	WERC	6	6
Fayette	Uniontown	WMBS	4	4
Fayette	Connellsville	WCVI	4	4
Franklin	Chambersburg	WCHA	4	4
Huntingdon	Huntingdon	WHUN	4	4
Indiana	Indiana	WDAD	4	4
Lackawanna	Scranton	WGBI	6	6
Lackawanna	Scranton	WSCR	4	4
Lackawanna	Carbondale	WCDL	4	4
Lancaster	Lancaster	WLAN	7	7
Lawrence	New Castle	WKST	7	7
Lebanon	Lebanon	WLBR	5	5
Lehigh	Allentown	WSAN	6	6
Lehigh	Allentown	WHOL	4	4
Luzerne	Wilkes-Barre	WILK	4	4
Luzerne	Wilkes-Barre	WBRE	4	4
Luzerne	Wilkes-Barre	WBAX	3	3
Luzerne	Nanticoke	WHWL	5	5
Luzerne	Hazleton	WAZL	5	5
Lycoming	Williamsport	WRAK	7	7
McKean	Bradford	WESB	4	4
Mercer	Sharon	WPIC	5	5
Mifflin	Lewistown	WKVA	4	4
Monroe	Stroudsburg	WVPO	4	4
Montgomery	Norristown	WNAR	5	5
Northampton	Bethlehem	WGPA	7	7
Northampton	Easton	WEST	5	5
Northumberland	Sunbury	WKOK	4	4
Northumberland	Shamokin	WISL	4	4
Philadelphia	Philadelphia	WCAU	8	8
Philadelphia	Philadelphia	KYW	7	7
Schuylkill	Pottsville	WPAM	4	4
Venango	Oil City	WKRZ	4	4
Warren	Warren	WNAE	4	4
Washington	Charleroi	WESA	4	4
Washington	Washington	WJPA	5	5
Westmoreland	Greensburg	WHJB	4	4
Westmoreland	New Kensington	WKPA	5	5
York	York	WSBA	7	7
York	Hanover	WHUR	4	4

AMA—Newspaper Advertising Campaign

The American Medical Association's advertising campaign is scheduled to run in 128 daily and 334 weekly newspapers in Pennsylvania.

The weekly newspapers will run the advertisement during the week of October 8. It will appear in the daily papers on October 11. All bona fide paid circulation newspapers in Pennsylvania will carry the AMA ad.

This message of freedom will reach 150 million Americans. It is conclusive proof that the doctors of America are determined in every way possible to increase the availability of good medical care to the American people through the medium of voluntary health insurance. American medicine wants to alert the American people to the dangers of socialized medicine and to those of all proposals which first limit freedom and then destroy it.

Respectfully submitted,

ALLEN W. COWLEY, *Chairman.*

SPEAKER BUCKMAN: The supplemental report of the Committee on Public Relations is referred to the Reference Committee on Reports of Standing Committees.

Supplemental Report of Commission on Graduate Education

To the President and House of Delegates:

Since our published report to the House of Delegates, the commission has held another meeting and wishes to report on two additional items of interest, one of which will require action by the House of Delegates or the Board of Trustees.

We take pleasure in reporting that the State Society has received national recognition for the program of the Graduate Education Institute. On Oct. 27, 1950, the chairman of our commission was present at a meeting of the American Trade Association Executives, where he was presented with a plaque, the inscription on which is appended.

The commission has prepared a special exhibit on the Graduate Education Institute program which it plans to use at many local, state, and national meetings throughout the ensuing year. We feel that this is not only good public relations for the Society but will also encourage other state societies to adopt similar programs.

The commission members are of the opinion that we may render additional service to the physicians in Pennsylvania by adopting a new type of program which will not conflict with our regularly scheduled meetings of the Graduate Institute. We hope to establish for general practitioners what might be termed semi-postgraduate internships. This instruction would be made available through hospitals with appropriate teaching facilities. It will be arranged so that one day each week, for a period of three to six months, a practitioner will take part in hospital activities, including the functioning of the clinics and ward duties. In this manner a teaching hospital will be able to instruct five men each week, one for each day of the week.

It is noted that this type of plan has worked successfully in the State of New Jersey.

Our commission has approved this plan in principle and the chairman has suggested that it be established on a trial basis. The fee to be charged will not be in excess of \$50 for a three-month period. The senior

faculty member and organizer of the program in each hospital would be paid an appropriate honorarium.

We would like to have the permission of the House of Delegates to proceed with these plans on a trial basis as briefly described in this report. Further details will be presented to the Board of Trustees at a later date.

Respectfully submitted,

CHARLES WM. SMITH, *Chairman.*

Plaque Inscription

American Trade Association Executives

Presents This

GRAND AWARD

for

Local, State and Regional

Associations

to The

Medical Society

of the State of Pennsylvania

for having rendered outstanding service to the industry which it represents as well as to the American public.

Jury of Awards

Chairman, Honorable Charles Sawyer,

Secretary of Commerce

Otto A. Seyforth, President,
Chamber of Commerce of the United States,
Washington, D. C.

Claude A. Putnam, President,
National Association of Manufacturers,
New York, N. Y.

Dr. H. B. Olsen, Dean,
Amos Tueck School, Dartmouth College,
Hanover, N. H.

Dr. Lee Bedgood, Past President,
American Association of Collegiate Schools of Business;
Dean, School of Commerce and Business Administration,
University of Alabama

Attest _____ /s/

Charles Sawyer
Chairman, Jury of Awards

SPEAKER BUCKMAN: This report is referred to the Reference Committee on Reports of Commissions.

Supplemental Report of Commission on Preventive Medicine and Public Health

To the President and House of Delegates:

The Commission on Preventive Medicine and Public Health has held one meeting since the formal report to the House of Delegates was prepared and published in the August issue of the PENNSYLVANIA MEDICAL JOURNAL. We should like to submit the following up-to-date statements in regard to the survey, *Keystones of Public Health for Pennsylvania*:

Item 1.—The Board of Trustees has considered and approved 11 chapters of the survey. Our commission is presently prepared to report to the Board on an addi-

tional 10 chapters. There have been no reports received from various commissions of the State Society in regard to four of the chapters. One of the chapters, namely, that dealing with the Codification of Public Health Laws in Pennsylvania, is being considered in great detail by the University of Pittsburgh and University of Pennsylvania Law Schools. We believe this study is in very capable hands and are looking forward to recommendations which they may make. In this respect we suggest that no legislation concerning the survey should be introduced into the 1951 Legislature until this research project is completed by the law schools. This project is supported by the Mellon Foundation which has granted \$147,000 for the project.

Item 2.—The commission, with the approval of the Board of Trustees, will distribute to each member of The Medical Society of the State of Pennsylvania a copy of the digest of the survey report entitled "Pennsylvania's Health Is Your Concern." A covering letter will explain the reasons for the digest and the background of the survey.

Item 3.—Three hundred copies of the complete survey report have been purchased from the Pennsylvania Citizens' Association and will be distributed to the members of the State Legislature when it convenes in Harrisburg in January, 1951.

We believe that the State Society has accomplished much in encouraging the adoption of many of the recommendations contained in the report. The commission members are well pleased with the support received from the various commissions of the State Society and wish to express to members of the House of Delegates their appreciation of their cooperation and support in this effort.

Respectfully submitted,

PASCAL F. LUCCHESI, *Chairman.*

SPEAKER BUCKMAN: This supplemental report is referred to the Reference Committee on New Business.

Supplemental Report of Committee on Procurement and Assignment (see page 1317)

SPEAKER BUCKMAN: This report is referred to the Reference Committee on New Business.

Are there any other supplemental reports to be presented?

The Chair recognizes Dr. Whitehill of the Board of Trustees.

**Supplemental Report of Educational Fund Committee
To the President and House of Delegates:**

In our committee's published report, page 29 of the transactions, reference was made to six requests for application forms for assistance from the fund, two of which had not been returned. Three approved 1950 applications were mentioned. Since July, when that report was prepared, one of the two "not returned" materialized and that application (son of a deceased member) was also approved, so that four young men are at present in school under the benefits of our educational fund. Two of these, if successful in college and accepted for medical school, will likely be applicants for assistance for the next seven years; another for

three years only; and the fourth possibly for nine years.

These boys, coming from families without resources, are all self-reliant and by their own labors will supply a considerable part of the total cost of their schooling. Each has been given to understand that continued assistance from the Educational Fund will necessitate high scholastic standing.

The members of the committee are well satisfied with their first year's experience and are hopeful of an increasing number of applicants for college entrance in 1951.

Respectfully submitted,

JAMES L. WHITEHILL, *Chairman.*

SPEAKER BUCKMAN: This is referred to the Reference Committee on Reports of Standing Committees. The Chair recognizes Secretary Donaldson.

SECRETARY DONALDSON: Mr. Speaker and Members of the House: It is a pleasure to be able to report that since our August 5 report to the House of Delegates, 105 members have paid their 1950 State Society dues, bringing the total of members paid to 10,386. In the same period, 91 members have paid their 1950 AMA dues, bringing the current total to 9713.

(Secretary Donaldson presented an invitation from the Woman's Auxiliary to the delegates to hear an after-luncheon address, "Students of Liberty," by the president of the Foundation for Economic Education, Inc.)

SPEAKER BUCKMAN: This supplemental report is referred to the Reference Committee on Reports of Officers.

The Chair recognizes Dr. Klump, chairman of the Board of Trustees and Councilors, for a report.

Supplemental Report of Board of Trustees

To the President and House of Delegates:

The Board of Trustees respectfully requests consideration by members of the House of Delegates of the following matters:

1. The Board of Trustees recommends that all members entering military service before June 1, 1951, shall be relieved from payment of 1951 dues.
2. A committee of the Board of Trustees is studying the question of the dues required from members who are serving as interns and residents. No action is requested at this time. However, the Board would welcome advice on this subject from any interested member.
3. The Board of Trustees offers the following resolution:

Resolution

WHEREAS, The Endowment Fund of the MSSP may be used only on approval of the House of Delegates, in annual meeting assembled; and

WHEREAS, It shall be used "for any purpose devoted to instructional and educational purposes that may be reflected in improved service to humanity under medical auspices," therefore, be it

Resolved, That the 1950 House of Delegates approve the reimbursement of the Society's general checking account in the amount of \$1,000, which amount the Board of Trustees in May 1950, appropriated to the Society's Commission on Acute Appendicitis Mortality for the purpose of making a survey of certain Pennsylvania hospitals interested in establishing certain "deshocking rooms" with specially trained personnel. In the

opinion of the commission, which is confirmed by research in teaching hospitals, establishment of such units would result in much earlier recognition and more effective treatment of ap-
proaching shock in a wide variety of medical and surgical conditions.

SPEAKER BUCKMAN: This supplemental report, together with the resolutions, is referred to the Reference Committee on Reports of Officers.

Are there supplemental reports from any of the several trustees and councilors? From any commissions?

[Dr. J. Parsons Schaeffer, Philadelphia, chairman of the Commission on Defense of Medical Research, presented a brief resolution in effect proposing to substitute the word "promotion" for the word "defense" in the title of the commission.]

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

Are there any other resolutions?

DR. C. L. PALMER: Mr. Speaker and Members of the House: This is not written in the form of a resolution, but it amounts to the same thing. It is entitled "Request for Consideration of School Health Examination Act."

Request for Consideration of School Health Examination Act

To the President and House of Delegates:

Inasmuch as certain questions have arisen concerning the School Health Examination Act, No. 425, the Department of Health of the City of Pittsburgh respectfully requests the House of Delegates of The Medical Society of the State of Pennsylvania to go on record favoring an investigation by the Commission on Public Health and Preventive Medicine of this act and its administration. The Commission on Public Health and Preventive Medicine is hereby requested to call on interested parties concerned in order to hear their complaints and suggestions, and report their findings to the Board of Trustees of The Medical Society of the State of Pennsylvania for their consideration.

C. L. PALMER,

Member of House of Delegates.

SPEAKER BUCKMAN: This is referred to the Reference Committee on Reports of Standing Committees.

Are there any others?

DR. WILLIAM BATES: This is a new resolution

Resolution

WHEREAS, An action of the House of Delegates of the American Hospital Association at its recent meeting at Atlantic City authorized the trustees of the American Hospital Association to establish a hospital standardization program; and

WHEREAS, The American College of Surgeons has expressed a desire to withdraw from the hospital standardization field, now, therefore, be it

Resolved, That the delegates of the Philadelphia County Medical Society recommend that the House of Delegates of The Medical Society of the State of Pennsylvania, at its annual meeting in Philadelphia in October, 1950, direct its members of the plans of the American Hospital Association to withdraw a hospital standardization program, either as an independent enterprise or as a transfer to the Hospital Association of the existing hospital standardization program of the American College of Surgeons, and be it further

Resolved, That any new hospital standardization program be a joint venture wherein the medical component of the program would set medical practice standards and the administrative components would set nonmedical standards; each group having representation on the board which would be the final authority; and be it further

Resolved, That this House of Delegates instruct the delegates of The Medical Society of the State of Pennsylvania to present the substance of this resolution to the House of Delegates of the American Medical Association at its meeting in Cleveland in December, 1950.

SPEAKER BUCKMAN: This resolution is referred to the Reference Committee on New Business.

DR. BATES: I have a second resolution.

Resolution

WHEREAS, The present restricted schedule of first-class mail deliveries and collections has resulted in serious inconveniences to the public; and

WHEREAS, This situation has been a particular hardship to physicians in the performance of their important professional duties; therefore, be it

Resolved, That the delegates from Philadelphia County recommend that the House of Delegates of The Medical Society of the State of Pennsylvania at its annual meeting in Philadelphia in October, 1950, go on record as strongly urging the prompt restoration of previous first-class delivery and collection schedules in the Post Office Department; and be it further

Resolved, That this House of Delegates instruct the delegates of The Medical Society of the State of Pennsylvania to present a similar resolution to the House of Delegates of the American Medical Association at its meeting in Cleveland in December, 1950.

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

Are there any other resolutions or supplemental reports?

I believe each member of the House recently received a report from the Medical Service Association of Pennsylvania. This is not an organization of The Medical Society of the State of Pennsylvania.

Report of Medical Service Association of Pennsylvania (Appendix A, page 1341)

DR. GUY H. MCKINSTRY (Washington): I would like to have the House of Delegates approve this report.

SPEAKER BUCKMAN: Dr. McKinstry wishes to bring this report onto the floor of the house. We will refer the report to the Reference Committee on Reports of Officers.

Does the secretary have correspondence to read?

SECRETARY DONALDSON: None.

SPEAKER BUCKMAN: It is always a pleasure to welcome to our meetings in Pennsylvania the representatives from neighboring state medical societies. I see Dr. James G. Reuling, vice-speaker of the House of Delegates of the American Medical Association and treasurer of the Medical Society of the State of New York.

DR. JAMES G. REULING: Mr. Speaker, President Samuel, and Members of the House of Delegates of the Sovereign State of Pennsylvania: Once again I take a great deal of pleasure in standing before you to bring you the good wishes of the Medical Society of the State of New York. President Wertz of our society will arrive later.

This is the Keystone State and in any arch it takes a keystone to make it stick. I come from the Empire State. Empires have risen and fallen in the past. I am not supposed to intimate to you that the Medical Society of the State of New York may rise and fall, but we do need your help and your assistance—speak-

ing as an individual, not as an officer of my state society.

Speaking as a citizen and speaking as an American doctor, I am vitally concerned with our parent organization, the American Medical Association. I am vitally concerned about the AMA dues. You all know that the state I come from has a very large leftist population. The record of the Medical Society of the State of New York in paying AMA dues, I am sorry to say, cannot approach the 94 per cent that I see here the State of Pennsylvania has paid in 1950.

There are at present four state medical societies in this Union that have made membership in the AMA a requirement for membership in the state society. I believe that this policy is fundamentally sound, and I sincerely hope the day will come when every state medical society will do the same. I am sorry to say that I am afraid my own state will be one of the last to adopt such a procedure. I think it would do more to strengthen medicine's stand in this country if such a resolution were adopted by The Medical Society of the State of Pennsylvania.

One other word, Mr. Speaker. The last time I had occasion to stand before you, I spoke of the investigations that were then being conducted in New York State and through many of our counties, my own county, Queens County, and their possible spread to Pennsylvania; I gave you the warning that they might. Today we have news that a Federal Government suit against the Oregon State Medical Society and several of its county societies alleging conspiracy in restraint of trade has been decided in favor of the medical societies.

Undoubtedly this decision will be printed in an early issue of the *AMA Journal*. The justice's findings there, I think, are going to be increasingly important to medicine, one being that the practice of medicine is not a trade. Of course, we don't know what will happen to it on appeal.

Once again my sincere thanks for the privilege of speaking to you and extending the best wishes of the Medical Society of the State of New York.

SPEAKER BUCKMAN: A truly great working secretary is the secretary of the American Medical Association. He was with us last winter at the annual Secretaries and Editors Conference. He came early and stayed through the conference to the end, taking an active part in many of the deliberations and giving a splendid address at the dinner. Dr. Lull has been invited to Philadelphia again this year to speak tonight at the state dinner, and he has shown us the great courtesy and an example of his great interest in us by coming early again to this meeting. He is with us this morning. I hope Dr. Lull will say a few words now.

DR. GEORGE F. LULL: Mr. Speaker, President Samuel, and Members of the House of Delegates: I bring you greetings from your national headquarters. You know the hard-boiled speaker and the vice-speaker of the House of Delegates of the American Medical Association do not like any interference with the work of the House; therefore, I shall not speak long. As a matter of fact, Drs. Borzell and Reuling were the cause of my receiving a letter of reprimand last year because a distinguished foreign physician told them he wanted to

appear before the House and he was introduced under advice that he should not speak. He went home and told his national organization that I hadn't shown him much courtesy; therefore, the letter of reprimand from the organization.

However, I am delighted to be here with you again. I am, of course, always glad to have an excuse to get back home, you know, and I hope to see a great many of you individually.

I hear in the House the same resolutions and reports of committees that I hear in the AMA house, exactly the same things, such as this American Hospital Association situation in which we are all so vitally interested and which has taken up a lot of the time of your national officers during the past month and is still being considered. We are hoping at the present time to see some daylight soon. You know we discovered what was going on by accident and it was almost an accomplished fact before we discovered it. We have opposed it bitterly and have given the American Hospital Association two or three opportunities to modify their action. As a matter of fact, two of our trustees and our president flew to Atlantic City from Chicago to appear before the board of trustees of the American Hospital Association. A week ago last Sunday we met all day in Washington and we are meeting all day again next month in Chicago. The American College of Surgeons has given us a guarantee that it will carry on this work until a suitable compromise is arrived at.

The compromise that we propose is that medical men must regulate the professional practice of medicine in hospitals. In the original negotiations it was proposed to set up a 25-man board to regulate all things having to do with hospitals. Six of the members of that board were to be physicians, three from the College of Surgeons and three from the College of Physicians—none from the AMA because they said they all belong to the AMA, and it was proposed that they would represent the AMA as well. Some were naive enough to believe that they would regulate the professional practice of medicine in hospitals. Just think of that, six out of twenty-five!

This, I think, is one of the most serious situations that has faced the medical profession in a long time, because it may mean that unless we regain or retain active control, the practice of medicine will fall into the hands of lay people and the regulations will be laid down in the hospitals for the practice of medicine by lay people. At present this has reached the point in some places where it might be subject to criticism by the professional groups.

I am very glad to be here and appreciate the opportunity of appearing before you.

(SECRETARY'S NOTE: On Oct. 21, 1950, the American College of Surgeons announced that at its meeting in the Hotel Statler, in Boston, the Regents of the College had voted unanimously to continue the hospital standardization program of the college.)

SPEAKER BUCKMAN: Is Dr. Stayer in the House? Colonel Glatty? [No response.]

We are ready to receive reports from reference committees under the head of new business. The Chair recognizes Dr. Fischer, chairman of the Reference Committee on Reports of Officers.

Report of Reference Committee on Reports of Officers (Continued on page 1327)

DR. HERMAN A. FISCHER: Mr. Chairman and Gentlemen of the House: I am prepared at this time to report the action of our reference committee on that portion of the business printed in the August issue of the JOURNAL. Supplemental reports, items referred to this committee during the session of the House of Delegates, and the address of the President we will present at another time.

Report of the Secretary-Treasurer: Membership figures show a decrease in total membership of 269 during the past year:

[1] 63 taken by death, 2 in excess of the previous year.

[2] 86, or 26 less than the previous year, have been lost by resignation, and 145 have moved from Pennsylvania, an increase of 23 over the previous year.

The number of associate members this year over the number one year ago may be explained by the 1950 increase in dues of many county societies, the inclusion of the AMA dues, and the 1950 increase in state society dues.

Perusal of the membership by counties suggests that the larger counties have suffered the loss, the smaller counties showing the gains. Of the 24 counties showing gains in membership, 14 are counties with less than 75 members, a very slight indication that the rural areas may be gaining from the membership changes.

One of the outstanding portions of the Secretary-Treasurer's report is that one application for malpractice has been approved and one case closed—a remarkable record for upwards of 10,000 members whose man-hours of labor cannot be estimated.

We rejoice with the Secretary-Treasurer in the 40 per cent increase in attendance at the Secretaries-Editors Conference in 1950, realizing that our inclusion this year of public relations chairmen helped to swell the attendance. However, of 60 component societies, 38 were represented by the secretary, editor, or both; 34 by the president or president-elect, and 31 by chairmen of public health and legislation, medical economics, or public relations—still far from 100 per cent—this despite the fact that the State Society pays all expenses. The suggestion that this might develop into an interim session is worthy of a great deal of thought and development.

The number of non-interest-bearing loans to veteran members repaid in full has been swelled to 20, and two are partially repaid. At the July meeting of the Board of Trustees, prompt distribution of the entire balance in the Veterans Loan Fund of The Medical Society of the State of Pennsylvania was authorized and this was accomplished during August, 1950.

Apparently, though the first portion of this report referred to the membership in smaller counties, suggesting a shift to rural areas, the problem of the physician for the smaller community has not been solved and remains acute.

The attitude of the medical profession toward its parent body, the American Medical Association, and the necessity of swinging an all-out educational campaign is reflected in the fact that 94 per cent of the dues-pay-

ing members of The Medical Society of the State of Pennsylvania also paid their annual AMA dues for 1950. No small share in the success of this collection belongs to the officers at the county level.

In view of the conclusion reached by the Secretary-Treasurer that the mathematical expansion of the Society's bookkeeping, namely, 297 checks issued in 1930 and over 2000 in 1950, served to reflect the need of more modern methods of bookkeeping service, your reference committee recommends that an adequate bookkeeping service be established.

The full accounting of funds of the organization as printed in the JOURNAL for September will be much appreciated by the members. A careful study gives not only a financial accounting but a story of the varied services performed by the Society for the benefit of both the public and its membership.

Mr. Chairman, I move the adoption of this portion of the report. [The motion was seconded, put to a vote, and carried.]

Report of Chairman of the Board of Trustees and Councilors: The committee joins in the welcome of Dr. Gilson Colby Engel as the newly elected trustee and councilor of the First District and Dr. Robert P. Banks of the Sixth District, both of whom have had wide experience in policies of medical organization.

The committee is thoroughly in accord with the reelection of Dr. Walter F. Donaldson as editor of the PENNSYLVANIA MEDICAL JOURNAL, of Mr. Lester H. Perry as executive secretary of the Society, and of Mr. A. H. Stewart as managing editor and convention manager. We deem such action just recognition of their talents and efforts.

We are all interested in the building expansion program and are happy to note the approach to completion of the remodeling of 226-230 State Street into a single building befitting an organization of our size and character and hope that in the near future all activities will be centered there.

The Educational Fund has begun to function, with four sons of deceased members enrolled in school in this its first year. Dr. Hess, the originator of the idea, has manifested his interest and belief in the fund by contributing \$1,000 toward it, a gesture this committee feels should be noted.

This committee has nothing but commendation for the committees responsible for the Graduate Education Institute and highly recommends its expansion and continuation. This society owes a great deal to the faculties of the several medical schools who have manned these centers at great personal sacrifice.

Keystones of Public Health, covered in the report of the chairman of the Board, have been subject matter in the last ten issues of the JOURNAL and will undoubtedly continue to be treated in further issues. The reports are far-reaching and will require further study before conclusive data can be prepared. The Board has supported with proper reservation the two Keystones approved by the 1949 House of Delegates, namely, a merit system for public health employees and the establishment of local public health units.

This committee would be remiss if it failed to note Dr. Klump's résumé of the duties of the Board mem-

bers, which is merely a summation, since most of the membership, though not openly revealing it, recognize the efforts put forth by the respective councilors and trustees in behalf of the Medical Society.

Mr. Chairman, I move the adoption of this portion of the report. [Motion seconded and duly carried.]

Report of the Editor: The affairs of the PENNSYLVANIA MEDICAL JOURNAL continue to be conducted on a high level; the contents of the JOURNAL have been above par, and its physical make-up has been brought up to the same level by improvements in cover design and expansion of line spacing more conducive to easier reading. There has been a distinct increase in editorials in the past year—63 as compared to 48 in the previous year—the Editor having been called upon to write 26 as compared to 25 the previous year. In so doing he has again amply demonstrated his versatility to the membership.

Mr. Chairman, I move adoption of this portion of the report. [Motion seconded and duly carried.]

Reports of Individual Trustees and Councilors: The report of each individual councilor is a summation of the activities of his particular district and they all portray a marked similarity in the problems arising in their respective areas and in their trend of thought relative to these problems. There are several items which more than one councilor elected to discuss:

1. Attendance at councilor district meetings. The councilors in four of the districts (2, 3, 4, and 12), representing some 22 counties of the State, have registered a distinct dissatisfaction with the attendance and are in favor of discontinuing these councilor district meetings. One of the councilors is not completely satisfied with the attendance, and would rather see them continued at the discretion of the councilor (Tenth District). Only one (Ninth District) comes out strongly in favor of continuing the meetings.

Your reference committee would offer a compromise recommendation as follows: That in each councilor district an annual poll of the component medical societies be taken to decide whether or not a councilor district meeting should be held, and, if so, the form it should take.

2. Two councilors spoke against the establishment of county grievance committees on the ground that they could be abused by the registering of unnecessary complaints. In view of the great difference in size of the component medical societies and the need of setting up a committee to which the public could appeal with just complaints, the reference committee would recommend that the censors of each councilor district act as the grievance committee of that district to accept, investigate, and act upon complaints from the public in addition to their present duties as outlined in Chapter IV, Section 3-A of the By-laws of The Medical Society of the State of Pennsylvania.

Mr. Chairman, I move adoption of this portion of the report.

SPEAKER BUCKMAN: The Chair will divide this portion of the report, if there be no objection from the floor.

The first question is the matter of continuation of councilor district meetings. The reference committee

offers a compromise to the effect that in each councilor district an annual poll of the component county medical societies be taken to decide whether or not a councilor district meeting should be held, and, if so, the form which it should take. The question, then, is on the adoption of this portion of the report.

DR. WALTER S. CORNELL (Philadelphia): Mr. Chairman, the Committee on Amendments to the Constitution and By-laws has before it already a resolution on this same proposition. It would seem to me that instead of adopting this resolution here, which more or less binds the House of Delegates, this matter should be submitted to the reference committee to consider along with the main amendment proposed.

SPEAKER BUCKMAN: Do you wish to move that this be recommitted to the reference committee or that it be referred to your committee or laid on the table?

DR. CORNELL: I suggest that it be referred to the Reference Committee on Amendments to the Constitution and By-laws. How can we consider the other material given us without taking this into account?

SPEAKER BUCKMAN: Dr. Cornell moves that the Reference Committee on Reports of Officers be discharged from consideration of this portion of their report and that it be referred to the Reference Committee on Amendments to the Constitution and By-laws. Do I hear a second?

[The motion was seconded by Dr. E. Arthur Whitney, of Delaware County.]

SPEAKER BUCKMAN: The question, then, is on the discharge of the Reference Committee on Reports of Officers and referring this particular question to the Reference Committee on Amendments to the Constitution and By-laws. Are you ready for the question?

[The speaker having put the question and received a unanimous affirmative vote, this portion of the report was referred to the Reference Committee on Amendments to the Constitution and By-laws.]

SPEAKER BUCKMAN: The second question or recommendation that was presented by Dr. Fischer in his reference committee's report had to do with the question of county grievance committees. It recommends that the district censors of each councilor district act as the grievance committee of their district to accept, investigate, and act upon complaints from the public in addition to their present duties.

DR. CORNELL: Mr. Chairman, I would like again to call attention to the fact that this matter of grievance committees is on the agenda for the Reference Committee on Amendments to the Constitution and By-laws.

SPEAKER BUCKMAN: Dr. Cornell, I think that one question laid before your committee simply has to do with a proposed amendment to the By-laws for the insertion of a few words, "or by the public." It does not involve an extensive change of the By-laws.

This reference committee recommends that grievance committees be not set up but that the district censors act as such. That is the question. Are you ready for the question?

DR. ELWOOD T. QUINN (Montgomery): Mr. Speaker, does that mean that we abolish our grievance committees in each county?

SPEAKER BUCKMAN: The recommendation is that the district censors in each councilor district act as the grievance committee in each district. It doesn't say anything about abolishing county grievance committees.

DR. CORNELL: Mr. Chairman, what is the essential difference between what we have just heard and what has already been printed in the JOURNAL as a suggested amendment to the By-laws? I can't see any difference. I mean we are asked to consider something that looks exactly like that referred to our committee at the meeting of our committee.

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report. If you wish to handle it differently, it is perfectly all right to offer a different method of doing it.

DR. CORNELL: Mr. Chairman, I move that it be referred to the Committee on Amendments to the Constitution and By-laws.

SPEAKER BUCKMAN: Together with the discharge of the reference committee on that question.

DR. CORNELL: Yes.

SPEAKER BUCKMAN: Dr. Cornell moves that the Reference Committee on Reports of Officers be discharged from the consideration of this question and that the question of grievance committees be referred to the Reference Committee on Amendments to the Constitution and By-laws. Do I hear a second?

[The motion was seconded by Dr. Wilbur E. Flannery, of Lawrence County, and carried.]

DR. FISCHER: That covers all the reports that were referred prior to the morning session.

SPEAKER BUCKMAN: We have the pleasure this morning, with the permission of the House, of reverting to communications or addresses. If I hear no objection, I will proceed to introduce Brigadier General Stayer, chairman of the Committee on Procurement and Assignment of Medical Officers. We will ask Dr. Stayer to address the House.

DR. MORRISON C. STAYER: Mr. Chairman, President of the Society, and Delegates: I am sorry that Colonel Glattly of the Second Army Area isn't here, but he will be here this afternoon and will speak to you about the reasons we want doctors.

I would like now to tell you what this committee that has been created by the Board of Trustees has done.

Supplemental Report of Committee on Procurement and Assignment

A meeting of the special committee of the Board of Trustees was held on Sunday, Aug. 13, 1940, to name members and activate a committee for the procurement and assignment of medical officers for the armed forces. Five physicians were named to this committee:

Morrison C. Stayer, Chairman
Paul G. Boyard, Treasurer
Gilson Collyer Esch, Philadelphia
Frank R. Harlow, Worcester
Doyl E. Worcester, Worcester

It was recommended that this committee be responsible for the following:

1. Organizing county procurement and assignment committees and supervising their activities.
2. Acting on cases of appeal from the county societies or from individuals.
3. Grouping the county societies together when those concerned are too small to operate individually in developing a Committee on Procurement and Assignment and instructing the county societies as to how to replace those inducted into the armed forces.
4. Making of any other regulations as required by changing conditions with the approval of the Board of Trustees of The Medical Society of the State of Pennsylvania.

After activation of this committee, the chairman and Dr. James Z. Appel, councilor for the Fifth District, represented the Society at an interstate procurement meeting on Aug. 17, 1950. Col. H. W. Glattly, surgeon of the Second Army, at headquarters in Fort George Meade, discussed the situation and announced the Pennsylvania initial quota of 55 medical officers of a certain type.

This committee met formally for the first time on Aug. 27, 1950, to discuss the procurement of a quota of 55 reserve medical officers as requested by Colonel Glattly. At this meeting the committee screened a file of 1000 reserve officers' records in order to procure the needed number. During the screening, five criteria were used in the selection:

1. Length of service.
2. Length of service overseas.
3. Number of dependents.
4. Age.
5. Essentialness of individual to community, hospital, or teaching institution.

The committee finally arrived at a list of 75 names which was sent to the Pennsylvania Military District headquarters in Philadelphia to insure the procurement of the needed 55 officers. All of the names on this list had been cleared by the county prior to their submission to the Second Army.

The officers on this list were then ordered up for a physical examination. Of the 75 men, 24 passed their "physical," 17 failed to report, 12 were disqualified, one had since died, three were listed as incomplete, one was over-age and 17 were unaccounted for due to various circumstances.

After a reduction in the initial quota, the committee finally submitted a list of 27 officers on Oct. 2, 1950. These doctors will be called to active duty on or about October 15.

I want to qualify that. As of this date, only 12 have been ordered out of the 27. For some reason they have been holding up the orders of the other 15. Of the 12, one went to Korea; the others went to hospitals in the States, the majority to Valley Forge.

The seven major problems with which our committee was confronted were:

1. Outdated information in present files which the Army turned over to us. (We sent out our own in-

formation forms, but only about 85 per cent were returned.)

2. The time-consuming job of calling each county society and the individual officer.

Your committee felt that it would be wise to telephone each person, not only the county committee but each doctor personally, and talk to him. It has paid large dividends. They then feel that The Medical Society of the State of Pennsylvania has a deep interest in their welfare.

3. The present residency regulations. (Most of the ASTP and V-12 trained men are in residency.)

We had an approval from the AMA and all the Army areas of the War Department, Defense and Second Army Area, that senior residents would not go. Last week I had a telephone message from the Surgeon General of the Army in which he stated that they had recently received information that residents would go no matter what they were in, whether first, second, or last year.

4. The change of the individual officer's specialty number (MOS) due to additional training since World War II.

That was because many of these doctors said: "I am not a surgeon or internist. You have got me wrong." So we were able to change their MOS to what they desired, having in mind that doctors when they go into service are able to continue in their special fields. We learned a lesson from the last war, and we hope that none of these men will be put into places to which they are not adapted. Through the Surgeon General's office we have been able so far to see that these men go into service in the various specialties in which they are interested.

5. The dissemination of information between the Army and the committee.

6. The fluid nature of the procurement problem.

The quota of 55 officers went down, went up, went down, until at last they got 27, and only 12 have received orders so far, as I told you.

7. The reluctance of younger men to serve.

I would like to qualify that because I still believe that many of these younger men want to serve their country. I will give you just one example. A youngster in Perry County, an ASTP, married to a nurse, has not been in service at all. He is in a district which has no doctor for miles and he is doing a good job. I told him that no doubt his community and we would protect him as much as we could; that is our business—the welfare of the community must be considered. But he said he had a moral obligation to go, and on his own he volunteered.

Apropos of this, I can tell you that these young physicians are now volunteering in considerable numbers. Many of them are applying for the Navy, but when accepted by the Navy they are ordered into the Army which needs doctors on a 5 to 1 basis compared to the needs of the Navy. If and when this balance is adjusted, such volunteers will be returned to Navy service.

The committee is still trying to organize and correct the records of the reserve officers. It anticipates another quota in the near future.

They told me the other day that they were going to give me a quota this week, but I have heard nothing of it. I think there is something back of it, for this reason: The President of the United States insists that these men who were deferred and who had no service and got their education for nothing must go before other people go. I think that is one of the reasons that the senior officers or men in the Reserve Corps have been held up, waiting to see what will happen.

The Draft

The recent decision on the "doctor draft" has also involved the committee. It has volunteered its services to Lt. Col. Henry M. Gross, state director of the Selective Service Commission. After several meetings with Colonel Gross, the committee has undertaken several other responsibilities at his request. These are:

1. Notifying county society procurement and assignment chairmen of draft regulations.
2. Informing them about the proper procedure of deferment methods.

A booth has been established at Convention Hall to accommodate doctors wishing to volunteer. On the back of this Form 390, which is a new one, is a place which states, "I request assignment to a service," whether it be Army, Navy, Air Force, or Public Health.

3. Undertaking the registration of doctors at the convention. (This arrangement was made with Colonel Gross's permission.)

4. Acting as an appeal board in remote cases directly through Colonel Gross.

We anticipate reporting directly to the Board of Trustees on financial matters and details of administration.

Plans for the Future

This committee is also undertaking the distribution of a questionnaire to all the physicians in the Commonwealth. This is quite an extensive questionnaire. Please fill it out and return promptly when received. Its information will prove invaluable to our own profession as well as to the government. This undertaking is being made possible through the mailing list of the State Department of Medical Education and Licensure. The information received will be placed on IBM cards and will provide a file of immediate information not only for this committee but for others, including the Emergency Disaster Committee. Copies of the returned questionnaires will be sent to each appropriate county society.

The committee in undertaking this giant task is helping the State Society to realize the long-felt need of having detailed information on every physician in Pennsylvania. Both the Society and the committees involved are encouraging the members to fill in and return the questionnaires as soon as they are received, which will be on or about the first of December.

In assigning these people I would like to bring this to your attention: It has been the feeling in Washington in all the defense areas, that is, the Secretary of Defense, Secretary of the Army and the Navy and the Air Force, that the men who have not served will

serve; that the men who have given their service will not be called up, even when they are in units. We will try to put in those units the men who have not served, who have the same ability as those who are there now. That keeps the unit firm and gives the men who have not previously done so a chance to serve their country.

The last thing I wish to say to you, gentlemen, is that while the work may be arduous, it affords us a closer acquaintance with many young and middle-aged doctors who are loyal, some of whom have established a practice, have gone into debt, and have a feeling that they are not being protected. But when we interview them personally rather than write them letters they are better satisfied. Some residents who are in the Reserve Corps have been deferred for a few months in order to complete their service. We have no desire to be abrupt. We try to be fair to the community, fair to the teaching institutions which are keeping up our standards, and fair to the armed forces.

SPEAKER BUCKMAN: Gentlemen, as a member of the State Committee on Procurement and Assignment in World War II, your speaker knows that it is a great deal easier to meet an issue face to face than to have it discussed critically throughout the community. This is a grand opportunity for you to ask General Stayer questions on this important problem, questions that may have been asked you at home and which you will be responsible to answer at home, having heard Dr. Stayer here.

DR. MORGAN D. PERSON (Lehigh): How many doctors other than reserve officers are likely to be called from Pennsylvania?

DR. STAYER: Up until the first of July, it is expected that 900 doctors will be called from the entire United States. When you see such a national call, divide the figure by 12 and it will give you approximately the number that will be called from Pennsylvania.

DR. MATTHEW J. BOLAND (Berks): Dr. Stayer, we have a problem—a member who served four years in the ranks and later obtained his medical education. What is his status?

DR. STAYER: His work as a soldier counts for nothing.

DR. BOLAND: He is subject to call?

DR. STAYER: Right.

DR. W. EDWARD CHAMBERLIN (Philadelphia): General Stayer, I was greatly heartened by your statement that you are succeeding in getting the young men kept in their specialties. Does that apply also to the Navy, or is it only with the Army that you have that success?

DR. STAYER: With neither the Navy nor the Air Force currently in need of medical volunteers, we have contacts only with the Army.

DR. CARL F. NIEL (Allegheny): I am acquainted with a young surgeon with five years' service in World War II, a reserve officer, and I believe he is on call at the present time. He has four children and his wife is dependent. What will happen to him since he is called for a certain date?

DR. STAYER: No doubt October 15. It all depends on his MOS. If, for example, he is an orthopedic surgeon and the Army has asked Pennsylvania specifically for two orthopedic surgeons, he may have to go unless a Pennsylvania doctor qualified as an orthopedic surgeon volunteers.

DR. WENDELL B. GORDON (Allegheny): Will your estimated number of approximately 40 per month from Pennsylvania until July 1 be reduced by the number of volunteers?

DR. STAYER: Yes.

DR. J. HART TOLAND (Philadelphia): We have a Pennsylvanian from our hospital who was ordered to be at Fort Sam Houston next Saturday morning. He is the father of five children.

DR. STAYER: Can you give me any information as to what he is? Is he an ASTP?

DR. TOLAND: He is an ASTP who served twenty months less four days. He has been ordered to Fort Sam Houston. His name is Thomas and his address is Feasterville.

DR. STAYER: I think I know the case.

DR. TOLAND: What is the reason for it, if you know it?

DR. STAYER: I don't know; because he was a MOS, he was in. I talked to that man, if I remember correctly, over the phone. I may be wrong on it, but before you leave here I will talk to you. Will that be all right? Because we have the papers here and I can talk with you.

SPEAKER BUCKMAN: Thank you very much, Dr. Stayer.

Gentlemen, we have with us also Col. Harold W. Glattly, of the Second Army. We will be very pleased if you will listen to Colonel Glattly at this time. Colonel Glattly says he also will be glad to answer questions following his talk. Colonel Glattly!

COL. HAROLD W. GLATTLY: Members of the House of Delegates, I want to tell you that it is a real pleasure to be back with you again. The fact that for two successive years you have made provision on your agenda for a member of the profession who wears the uniform is to me indicative of the close relationship and liaison that presently exists between civilian and military medicine.

When I reported to you last year on this occasion, you may remember that I made specific mention of the material contributions that certain members of your society were making to assist us in providing good medical service to the troops in the Second Army Area, at a time when we had lost about 75 per cent of all of our medical officers. I want you to know that that support has continued throughout the year.

You might be especially interested in knowing that the rather ingenious plan, the lend-lease resident plan, that was developed here in Philadelphia by Dr. Ravdin in collaboration with the department heads of the medical schools and hospitals here in the city helping us, to staff our two largest hospitals, has functioned smoothly and efficiently for well over a year and it has been the

means of providing a standard of medical service to our troops at Camp Knox and Camp Campbell such as was far beyond our own resources.

I had hoped last spring, as I looked forward to this occasion, to be able to come before you and tell you that our problems were fast being resolved. Although last spring we had fewer medical officers available to meet our operational requirements than at any time since the war, we, nevertheless, were extremely optimistic, because in July we graduated our first class of interns and residents who would be immediately available for operational assignments. Our intern and residency programs had been so successful as procurement devices that we had every reason to believe that by July, 1951, the Medical Corps would be well on its way back to normal.

Then on the 25th of June the North Koreans struck, and a few days later the President announced that our ground forces would be committed to action in support of the South Koreans. At that time we had in Japan barely enough medical officers to carry on the ordinary sick call and in-patient care of our troops out there. Our field medical units, including those in the division, units such as mobile surgical hospitals, evacuation hospitals, and so forth, were staffed with less than 10 per cent of their normal complement of medical officers.

To meet this critical situation, the Surgeon General immediately after the onset of hostilities flew to Japan practically every medical officer who was in residency training. By reason of the fact that we did have this professional training program, we were able to furnish to General Hume, the surgeon of the Far East command, practically everything he asked for in both the quantity and the quality that was desired. It was indeed fortunate that we had this pool of highly trained young medical officers.

I can say (and I think General Stayer will bear me out) that never before in any war have we been able to put so much talent into these field medical units as we put in the evacuation hospitals and mobile surgical hospitals that were supporting our troops down there on the Pusan beach head, more or less, as it was called. They turned out a splendid record of achievement.

You are all familiar with the phenomenal record made by American medicine in World War II, when they saved 95 out of every 100 wounded that reached a medical aid station. According to our latest figures, that record has been excelled in Korea; 49 out of every 50 wounded have been saved, and they include a high percentage of seriously wounded litter cases. I am sure that I don't need to say any more than that to those of you who should justly have some concern with respect to the caliber of professional care that we are going to be able to give our battle casualties over there.

This, of course, was accomplished only by reason of the tremendous expenditure of individual effort of the various people who were over there. We have reports of surgeons and their teams working without relief for two and three days at a time in our mobile surgical hospitals. Our *casualties among medical personnel were quite high*, especially our medical aid men.

I think, gentlemen, that this Korean campaign is going to go down in history as one of the grimmest types of warfare that American troops have ever experienced.

In spite of the nice little lines that you saw drawn on the war maps that were printed in the papers, we never had a line in Korea, we never had enough troops to man a line. All we had were some strong points with wide gaps between through which the enemy could infiltrate in large numbers at night, and our men would then be subject to attack not only from the front but from the rear, the left or the right. There was no such thing as safety behind the lines. Our ambulances were ambushed carrying patients back to the rear. We had aid stations overrun, with all medical personnel and patients shot or bayoneted. One medical officer was found shot with his hands tied behind his back. I know we are all thankful, at least we hope, that the worst part of this present campaign is behind us.

Not only were we faced with the necessity of supporting this campaign but we also had the problem of providing medical support to a rapidly expanding army. We were inducting national guard and reserve units at a fast pace, many of them with only half strength it is true, but we had to bring them up to full strength at the earliest possible time. Fifty thousand draftees were coming in a month. We were opening new camps and stations, two of them in our own area, one at Breckinridge, Kentucky, another at Camp Pickett in Virginia.

Now, although Congress in early August was considering a bill that would make available to the armed forces the vehicle of selective service to provide us with the necessary number of medical professional persons, nevertheless, it was recognized that three or four months must of necessity elapse after the passage of that legislation before anybody would actually be made available. So the Army was faced with making a decision as to whether to cut back on the tempo of mobilization or to involuntarily call to active service medical reserve officers nearly all of whom had had World War II service.

I can assure you that we recognized the inequity of again dislocating the lives of those physicians, but our volunteer campaign had come to nothing. So on the 11th of August each of the six continental armies (we are in the second here, you know) was given a quota of medical reserve officers by grade and by specialty to involuntarily order into the service. Now, it would have been a lot simpler for me, and I know it would have been for General Stayer and his committee, if I simply had gone to our International business machine, punched a few keys and out would have come the names and grades and specialties we wanted; but we didn't want to do business that way. We wanted to make the most equitable selection possible, considering both the individual and the community he served or the institution where he was practicing. We thought we could best accomplish this by working through the state medical societies. So our army commander, Lieutenant General VanVliet, addressed a telegram (I don't know what General Stayer said in his remarks; I may be repeating) to the presidents of the several state medical societies within the Second Army, asking for their assistance and advice and inviting them to a conference at Fort Meade. We held this conference on August 17. We received within twenty-four hours, I think, favorable replies from every one of the states.

At this conference, as you know now, it was agreed that a committee would be set up in each state which would make the selection from rosters furnished by us. You already know that General Stayer was named to head your State Committee on Procurement and Assignment. I want to state here that we are deeply appreciative at Fort Meade of the splendid cooperation that we have received from General Stayer and his committee. Even under the best of circumstances it would have been a very unpleasant task. I do not think you could have arranged more adverse circumstances for a committee to operate in than have existed during the month of September, especially after the passage of Public Law 779.

Pennsylvania met its full quota. I haven't had a chance to talk to General Stayer yet, but this morning I brought some papers with me that will enable him to take a few of the gentlemen off the hook that he now, I think, has on the hook.

I won't take any more of your time, but in case any of you would like to ask questions I will be glad to do what I can to answer them. I am sorry that Dr. Ravdin isn't here, too. He, I understand, is going to participate as medical adviser in your selective service. Someone has said that there has been so much misinformation printed in the papers about this doctor draft act that I would like very much for those of you who are interested and care to stay to give you the system by which we intend to insure that no doctor is going to be pulled in as a buck private, sent to Fort Knox, and do squads north and squads east for fourteen weeks.

DR. STAYER: I want to say this about Dr. Ravdin's committee—it is the committee for selective service which we are trying to coordinate with our committee.

COLONEL GLATTLY: If any of you are interested, I will be glad to tell you the mechanics of how it is going to be accomplished. We think that we have effected reforms with respect to the utilization of doctors in the service so that we will no longer be subject to, may I say, perfectly legitimate criticisms that ensued from the manner in which we utilized them in World War II. I especially refer to malassignment and to the various hurry-and-wait sort of mobilizations.

SPEAKER BUCKMAN: I would like to introduce Dr. Carlton E. Wertz, of Buffalo, president of the Medical Society of the State of New York.

DR. CARLTON E. WERTZ: Mr. Chairman and Dr. Samuel, I am sorry I was late arriving this morning, but that is one of the things that happens when traveling by plane.

It is an honor and a privilege to be here today at your one hundredth anniversary meeting and to bring you the best wishes and greetings of the Medical Society of the State of New York. We feel very neighborly with Pennsylvania, as it is along our borders for quite a number of miles. We wish and hope that this friendship between the two societies will be even more closely cemented.

I feel that there is a great opportunity for adjacent societies now. They should have more frequent conferences and discuss many of their common desires and aims.

You have had quite a session this morning. The previous speaker gave us lots to think about. As medical men, you know we always have enough to do, but now with this world-wide situation we have some more obligations to undertake such as continuing to take care of the civilian population as well as we have in the past and seeing that the Army and Navy have all the personnel they need; also, we need the medical people to take an active part in the civilian defense program.

Again, I want to thank you for the privilege of saying hello.

SPEAKER BUCKMAN: This morning Dr. Palmer presented a supplemental report which was entitled "Request for Consideration of School Health Examination Act." The Speaker referred it to the Reference Committee on Reports of Standing Committees. It has been pointed out that it might better be referred to the Reference Committee on New Business, since they have already had referred to them the report of the Commission on Preventive Medicine and Public Health.

The Chair will entertain a motion that the Reference Committee on Reports of Standing Committees be discharged from consideration of this question and that the question be referred to the Reference Committee on New Business.

DR. C. L. PALMER (Allegheny): I so move.

[The motion was seconded by Dr. Charles L. Fackler, York County, and carried.]

SPEAKER BUCKMAN: There are a few announcements, then the Chair will entertain a motion for adjournment with a time specified for the next meeting.

[Announcements of reference committee meetings, etc.]

SPEAKER BUCKMAN: Are there any other communications or announcements to be made? If not, we will entertain a motion for adjournment.

DR. THOMAS W. MCCREARY (Beaver): I move that we adjourn until three-thirty this afternoon.

[The motion was seconded by Dr. Charles L. Fackler, York County, and carried.]

[The meeting adjourned at twelve-fifteen o'clock.]

LEWIS T. BUCKMAN, *Speaker,*

WALTER F. DONALDSON, *Secretary-Treasurer.*

Monday Afternoon, Oct. 16, 1950

The second session of the House of Delegates convened at three-forty o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will be in order.

The Chair recognizes Dr. Wilson, chairman of the Committee on Credentials.

DR. FRED B. WILSON (Beaver): There is a quorum present.

SPEAKER BUCKMAN: With the permission of the House, we will dispense with the roll call.

If there be no objection from the floor, we will dispense with the reading of the minutes of this morning's meeting.

Is Dr. Fischer in the house, the chairman of the Reference Committee on Reports of Officers? If not, the Chair will recognize Dr. Russell B. Roth, of Erie, chair-

man of the Reference Committee on Reports of Standing Committees.

Report of the Reference Committee on Reports of Standing Committees

Committee on Public Health Legislation: It is the conviction of your reference committee that every member of The Medical Society of the State of Pennsylvania must become politically informed and politically active if he is to discharge his obligations as a good citizen. It is a tribute to the activities of the Committee on Public Health Legislation that the complex task of becoming reliably informed on legislative and political matters has been immensely simplified by its efforts, and the channels through which political activity may be effectively, ethically, and legally directed have been clearly defined. It is hoped that the individual members of the Society will cooperate with their county and state legislative committees in staunchly opposing the multiple proposals for unwarranted Federal subsidization of health matters with the ever-present implication of Federal control over the character and quality of medical practice, and that they will just as resolutely promote those legislative programs which have the approval and the backing of ethical medical organizations.

It has become apparent during the past year that doctors may make themselves into a potent political force, working for the good of their local governments, their states, and their country. They may speak in considered, authoritative tones which cannot be shunted down by vocal, unscrupulous minorities, be they cultists, opportunists, or Marxian dreamers. The task is tremendous and unending. Incalculable damage to the welfare of the nation may be done if the charlatans, the crackpots, and the political plum-suckers are permitted to sell their dubious wares. Inasmuch as it has been the function of this committee, in conjunction with a similar committee of the American Medical Association, to maintain a vigilant watch on all proposed Federal and state legislation, to analyze and digest this material, and to present it in a form assimilable by the busy physician, it would be inappropriate to abstract further the report.

It is the recommendation of your reference committee that every physician of the Society read not only the full text of the annual committee report but also the more detailed bulletins issued by the committee during the coming year. It is further recommended that individual members and their families stand ready to notify their elected representatives of their views on controversial and critical issues. He who sits inert and mute while adverse legislation passes engages in malpractice of the art of citizenship.

Your reference committee commends the degree to which the Committee on Public Health Legislation has utilized its legal counsel and the extent to which it has cooperated in the shaping and promoting of desirable, progressive legislation within the State.

It is noted that the activities of the committee in the past have been hampered by incomplete cooperation from county committees in the matter of returning questionnaires. Your reference committee can only call for increased county activity in such matters of cooperation.

Your reference committee is particularly impressed

with the magnitude of the task of superintending the relationships of the medical profession with the legislators of our state and of our nation. Prior to the time when medicine was reluctantly dragged into the political arena, this represented a relatively small proportion of medical concern. Today it has become a subject of preoccupation. It impresses your committee as unjust to expect one individual, however capable he may be, to be charged with the simultaneous responsibility for the State Healing Arts Advisory Committee, the Committee on Rural Medical Service, the Advisory Committee to the Department of Vocational Rehabilitation, and other subsidiary and even unrelated activities. It is our strong recommendation to the Board of Trustees not only to grant the physical, secretarial, and legal assistance in the Harrisburg office which has been requested by this committee but also to devote prompt attention to the possibilities of augmenting, strengthening, or altering the composition of this committee so as to best adjust it to current needs.

It is the unhesitating recommendation of the reference committee that the Committee on Public Health Legislation be granted a continuation of discretionary powers in carrying on necessary activities relating to legislative problems, in consultation with the Board of Trustees and appropriate committees and commissions of the Society.

Mr. Chairman, I recommend adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on the adoption of this portion of the reference committee's report. Are you ready for the question?

[Motion was duly seconded and carried.]

Committee on Public Relations: Your reference committee subscribes to the belief that when the public is fully informed as to the accomplishments, the aims, and the potentialities of the medical profession, it will disclaim all interest in foisting upon that profession the shackles and red tape of political control. The National Education Campaign of the American Medical Association, as implemented in this State by the Committee on Public Relations, has made great progress toward this goal through the media of the press, the radio, television, the speaker's rostrum, plus assorted projects of informative value, such as health exhibits and county health fairs. The case for free enterprise medicine has been placed squarely before the people. It must continue to be so presented, forcefully and frequently. But of even more significance than the words spoken in medicine's behalf are the accomplishments of the profession in terms of service. Perhaps foremost among these increased services is the expanding movement to provide emergency medical care available to all, in all quarters of the State. Next must come health education, through newspaper columns, films, radio talks, television shows and exhibits. The Committee on Public Relations and its augmented professional staff have worked energetically and fruitfully on the generation and correlation of such activities. That which has been done has been done well.

It only remains for your reference committee to voice a supplementary opinion. There is less criticism of the quality of medical care than of its cost. There may be less difficulty in finding good medical attention than in

paying for it. There may be a persisting discomfort from an economic pinch that is felt long after the last physical malaise has disappeared. It is incumbent upon us to offer to the public some better remedy for this than the illusive promises of the "something-for-nothing," tax-financed booby trap of compulsory health insurance.

Your reference committee is not unaware of the emphasis which has been placed on voluntary health and hospitalization insurance, and the vast growth which such insurance plans have shown. Your committee does recommend, however, that the promotion of voluntary insurance be even further pressed. Free-enterprise, profit-making insurance deserves greater co-operation from free-enterprise medicine, and insofar as the medical profession is identified in sponsorship of the non-profit insurance plans, it should stimulate an increased range of coverage and benefits. We must accept the indisputable fact that the public fails to discriminate between the costs of hospitalization, of drugs, of laboratory and x-ray examinations, and the fee of the physician. The high cost of medical care, though not especially of our making, is a problem which we must face. Only when the overwhelming bulk of the nation's people are protected against the high costs of illness through the medium of voluntary insurance will the cry for Federally financed insurance die away. It is the opinion of your reference committee that it is within the province of the Committee on Public Relations to attempt still further to reinforce the educational assault upon those multitudes among us who can afford to insure themselves but who have not chosen to do so; to attempt still further to substitute education for compulsion.

Your reference committee salutes the current accomplishments in the field of public relations and expresses its earnest hope that efforts of equivalent character shall be continued.

I recommend the adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on the adoption of this portion of the reference committee's report which deals with the report of the Committee on Public Relations. Are you ready for the question?

[Motion was duly seconded and carried.]

Committee on Archives: Your reference committee notes with interest that the archivists of the Society report a "strangely sterile experience" throughout the last year, having accumulated only a copy of a proposed but unauthorized charter drawn up by the State Society in 1869. It is assumed that the committee is not unaware that the transactions of today become the treasured documents of tomorrow, and that the records of our present struggles to preserve the freedom of enterprise in the profession may some day provide the medical historian with his most significant material. We may here today be recording significant chapters in either the triumph of an ideal or the passing of an era.

Committee on Necrology: Your reference committee is tempted to observe that despite the fact that the doctor, through the nature of his work and the courtesies of his profession, seldom lacks for the finest which is

available in medical care, either because of inaccessibility or inability to pay. Still it is noted that the statistics of the necrologist show that neither the abundance nor the availability of fine medical care have extended the life span of the physician beyond that of his average fellowman. Perhaps it is not all as simple as the statisticians of the Federal Security Administration opine. Your reference committee regrets that not even socialized medicine could have spared us the passing of so many fine colleagues.

Committee on Educational Fund: Your reference committee has taken great satisfaction from its critical appraisal of the accomplishments of the newly created Educational Fund. That four sons of deceased members of our society are now enabled to pursue medical studies which would otherwise have been beyond their financial reach is evidence enough that this fund meets a real and valid need. The thought that future beneficiaries will be the sons and daughters of our present numbers should guarantee our enthusiasm for perpetuation and augmentation of the plan. The committee is commended for its wisdom and its painstaking care in translating this plan into reality.

I recommend adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on the adoption of this portion of the report having to do with the reports of the Committee on Archives, the Committee on Necrology, and the Committee on Educational Fund. Are you ready for the question?

[Motion was duly seconded and carried.]

Committee on Medical Benevolence: Your reference committee can only commend the continuing interest of the Woman's Auxiliary in the Benevolence Fund and express the gratitude of the Medical Society for the financial support which makes the continuance of this fund possible. During this past year 28 persons, aged or incapacitated physicians, widows and children, have gained well-deserved assistance from this source. The careful stewardship of this fund by the Committee on Medical Benevolence deserves special mention.

Advisory Committee to Woman's Auxiliary: This committee has not met during the past year, although its individual members have conferred with the officers of the Woman's Auxiliary as often as occasion has demanded. It only remains to note that the committee has expressed a well-deserved tribute to the energy and accomplishments of the Woman's Auxiliary which your reference committee takes pleasure in seconding.

Committee on Rural Medical Service: This committee has been instrumental in establishing the Pennsylvania Health Council, Inc., with committees on budget and finance, on membership, on program, and on public relations and education. Organizational details and by-laws have been published in the May issue of the PENNSYLVANIA MEDICAL JOURNAL. It is to be anticipated that this council will become a valuable instrument in coping with the health problems of the Commonwealth.

The committee has continued to devote attention to the problem of supplying physicians to areas, particularly rural communities, in which they are needed. As a medium for establishing contact between physicians seeking locations and communities seeking medical care,

the activity of the committee in maintaining appropriate listings is commended. The opportunities for cooperation with the newly established Pennsylvania Health Council are fully appreciated.

I recommend adoption of this portion of the report.

[Motion was duly seconded and carried.]

Committee on Medical Economics: There have been no formal meetings of this committee during the past year. It is noted that, as defined in the By-laws of The Medical Society of the State of Pennsylvania, Chapter VII, Section 18, "this committee shall consider all questions dealing with proposals for the expansion of health and medical service in Pennsylvania by State or Federal bureaus or by lay organizations as they may be referred to the committee by the House of Delegates or the Board of Trustees and Councilors. It is a fact-finding body and shall report annually to the House of Delegates. Its chairman shall attend or be represented at regular meetings of the Board of Trustees and Councilors."

The chairman has fulfilled his obligations as defined and the committee has been assigned no problems. Information on the medical, health, and hospital program of the United Mine Workers has been disseminated, and minor changes in the Veterans Administration fee schedule have been approved. It impresses your reference committee that the House of Delegates and the Board of Trustees and Councilors might well make more use of this potentially valuable committee in these days of increasing Federal and State subsidies and expanding health programs. It would seem that there has been too ready an inclination to heap upon the already burdened shoulders of the Committee on Public Health Legislation duties which may more properly belong to the Committee on Medical Economics. Your reference committee makes one specific recommendation. Because voluntary insurance appears to be the only feasible alternative to compulsory insurance, and because voluntary insurance coverage against the costs of illness is capable of great increase in this state, it is recommended that the Committee on Medical Economics devote itself during the coming year to a study of ways and means of coordinating the efforts of the Medical Society and its members with commercial as well as non-profit insurance organizations in promoting wider coverage in the State.

I recommend adoption of this portion of the report, which covers the report of the Committee on Medical Economics and carries with it a definite recommendation from the reference committee.

[Motion was duly seconded and carried.]

Committee on Psychiatric Services to Criminal Courts: During periods in which the State Legislature is not in session such a committee as this is, of necessity, relatively inactive. The persistence of the committee in working toward ever-improving management of this difficult problem is to be commended.

Committee on Workmen's Compensation Laws: Once again the absence of activity of the State Legislature has enforced inactivity upon a committee. Your reference committee feels that it is quite appropriate that this committee keep before it the oft-repeated statement

that Pennsylvania is a backward state in respect to its workmen's compensation laws, and that it bend its efforts to the promotion of remedies for this situation. It is apparent that the committee fully realizes its responsibilities.

Committee on Telephone Directory Classification: The petty annoyance of distorted telephone listings by cultists appears to have been terminated in this state, and the committee which has had this for its province deserves our gratitude.

I recommend adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on the adoption of this portion of the report, having to do with the reports of the Committee on Psychiatric Services to the Criminal Courts, Committee on Workmen's Compensation Laws, and the Committee on Telephone Directory Classification. Are you ready for the question?

[Motion was duly seconded and carried.]

DR. ROTH: I move adoption of the report as a whole.

[**EDITOR'S NOTE:** The Reference Committee on Reports of Standing Committees consisted of the following members: Daniel H. Bee, Indiana; Charles L. Faekler, York; William F. Brennan, Pittsburgh; Joseph J. O'Brien, Scranton; and Russell B. Roth, Erie, chairman.]

SPEAKER BUCKMAN: The question is on the adoption of the report as a whole. Are you ready for the question?

[Motion was duly seconded and carried.]

SPEAKER BUCKMAN: The chair recognizes Dr. Joseph J. Toland, Jr., chairman of the Reference Committee on Reports of Commissions.

Report of Reference Committee on Reports of Commissions

Commission on Cancer: The fruit of the excellent work of this commission is manifesting itself in many ways, and in particular, first, in more thorough examination of patients through the five points recommended by the commission; second, early recognition of suspicious cancer lesions; and, third, recommendation of earlier treatment. The reference committee recommends the coordinating of cancer programs more from the district and county level. The commission is commended for its untiring efforts and its continuation is recommended.

Commission on Child Health: This commission recommends a subdivision of pediatrics in the Section on Medicine. Your reference committee feels that the revision made of the Scientific Work Committee in 1948 was in the interest of better scientific programs for the benefit of general practitioners, and we do not support this recommendation of the Child Health Commission for a separate section on pediatrics. We do, however, support their recommendation that pediatrics be included in the Graduate Education Institute. We approve the remainder of the report and commend the members of the commission for the work done and continuation of a Child Health Commission.

Commission on Conservation of Vision: We recommend that this report be approved and that the commission be commended for its efforts, first, in standardizing the treatment for prevention of ophthalmia neonatorum; second, its attempt to have legislation passed to prevent the sale of dangerous toys.

Commission on Deafness Prevention and Amelioration: We recommend adoption of this report and continuation of the commission, with the hope that its efforts will be fruitful.

Commission on Defense of Medical Research: This commission has completed a Trojan job and merits the support and cooperation of all our members in support of Bill No. 278. Its continuation is recommended.

Commission on Diabetes: This commission is carrying out its program as planned and is reaching all physicians as well as the public through its educational program. We commend its work and recommend continuation.

Commission on Graduate Education: This commission should have the thanks of all our members. Its institute has been well attended and the interest has been excellent. It is gratifying to learn that diplomas will be presented at the installation meeting to those who attended the courses for three years and were present at least 70 per cent of the time.

Commission on Industrial Health and Hygiene: This commission is commended for its present efforts and its continuation is recommended.

State Healing Arts Advisory Committee: Your reference committee approves both the published report and the supplemental report of this committee and commends it for its untiring efforts.

Commission on Laboratories: This commission has presented no formal report. Its continuation is recommended.

Commission on Nutrition: This commission was reactivated during the past year under a new chairman, and its continuation is recommended.

Commission on Physical Medicine and Rehabilitation: This commission is commended and its plans endorsed. Continuation of the commission is recommended.

Advisory Committee to Pennsylvania Board for Vocational Education: Your reference committee recommends that this report be received, and since the purpose of the committee has been fulfilled we recommend that it be discharged with thanks.

Mr. Chairman, I move the adoption of the report.

[**EDITOR'S NOTE:** The Reference Committee on Reports of Commissions consisted of the following members: William J. Corcoran, Scranton; Dudley P. Walker, Bethlehem; Frank E. Butters, Franklin; Mary B. Davis, New Castle; and Joseph J. Toland Jr., Philadelphia, chairman.]

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report.

The Chair asked Dr. Toland to insert a recommendation for continuation of the Commission on Conserva-

tion of Vision and on Graduate Education. The recommendation was not in the typed report. Consequently, your adoption of his recommendation will carry with it continuation of these commissions as listed. Are you ready for the question?

[Motion was duly seconded and carried.]

With the permission of the House, the Chair will set aside the regular order of business to receive Dr. Joseph S. Lawrence, of the Washington Bureau of the American Medical Association, with the hope that he will address the House for a few minutes. Dr. Lawrence!

DR. JOSEPH S. LAWRENCE: Mr. Speaker, Mr. President, Mr. Secretary, and Ladies and Gentlemen: This is the time I have been taken off my guard. I did not arrive until this afternoon but I do appreciate hearing the reports that you have listened to and adopted.

I am very much interested in the way they were put and the support they received from you. I think that, outlined as they were, you have some activities under way which tend to make a medical society the active agency that it should be.

I am not going to talk much about legislation which, after all, is the subject that I know most about, except to commend the chairman of your legislative committee and your legislative committees, county and state, for their ardent support of what we are doing in Washington. It has helped immeasurably in the things we have done and the support that we get helps make it more important. I don't know just how to abbreviate it, but we are in the position at this time of having accomplished during the past year all that, in a measure, we set out to do. That is, we didn't have to suffer the defeat of any particular bill. We probably didn't accomplish as much as we would like, but we are in a position where Congress respects the ideas of the medical profession. We need your continued ardent support.

I heard mentioned here that you intend to devote during the coming year more attention, more time to voluntary health insurance programs, both as they will be sponsored by the physicians and by commercial companies. This is a most excellent objective, and I hope that you will put yourselves to it as diligently as you possibly can.

Our continued success in Washington will depend, without doubt, upon any ingenious methods which we offer as a substitute for the Government's health insurance plan. Undoubtedly we will have to modify some of the positions we took last year in order to accommodate ourselves to the way things are moving forward at the present time. This subject of health insurance, I feel very confident, has gotten beyond the academic stage. People are generally wanting to know what we can do, and they are preparing to make compromises. So let us study carefully what is before us.

We will have a more difficult time this next year in meeting the bills that will come into the Congress than we did last year. This demand has advanced to the point where people definitely want something specific; we are in a position to provide that something and we are anxious to do it. No one must gain the impression that we are not sincere and persistent in our determination to provide adequate medical service

on a voluntary insured basis whether it be by Blue Shield or commercial insurance companies.

SPEAKER BUCKMAN: Thank you very much, Dr. Lawrence.

The Chair recognizes Dr. Stanley D. Conklin, of Sayre, chairman of the Reference Committee on Scientific Business.

Report of Reference Committee on Scientific Business

Commission on Maternal Welfare: The commission reports that its work for the year was handicapped for several months, due to a change in the system of filing, coding, and indexing deaths inaugurated in the State Department of Health. Because of this unavoidable situation the commission was unable to allocate the death certificates to the county society chairmen for their study. The partial report of the commission indicates that the final maternal death rate for 1949 will compare favorably with that for 1948 which was slightly over 1 per 1000 live births. The commission reports that a survey of health in Pennsylvania in 1945 by the American Public Health Association shows that Pennsylvania stood 31st in puerperal deaths. Since that time, there has not been a significant decline in the maternal death rate, so our position would be about the same today. A review of the causes of maternal deaths clearly indicates that some of these could have been prevented. The commission again requests the full cooperation in this work of each physician who has a maternal death, especially the general practitioner. The reference committee believes the objectives of this commission are highly desirable and recommends its continuation.

Commission on the Control of Syphilis and Venereal Diseases: Your reference committee recognizes that this commission has been more active this past year. It had an active part in the survey report entitled "Keystones of Public Health for Pennsylvania," a conference with the Chief of the Venereal Disease Division, Pennsylvania Department of Health, distribution of the booklet, "The Control of Syphilis by Means of Penicillin," to the physicians throughout the State and at the graduate seminars, and publication of a second booklet by the Department of Health, "Syphilis and Penicillin in 1950." The commission reports that it has been asked by the State Department of Health for assistance in studying the venereal disease problem in private medical practice and expects to make this one of its chief activities during the coming year.

Continuation of this commission is recommended.

I move adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on the adoption of this portion of the reference committee's report covering the reports of the Commission on Maternal Welfare and the Commission on the Control of Syphilis and Venereal Diseases. Are you ready for the question?

[Motion was duly seconded and carried.]

Commission to Study Control of Rheumatic Fever: This commission's report indicates that it has been very active this past year. A well-organized state-wide program is in operation. During the year a new integrating group was developed, consisting of the members of the commission itself, members of the Division of Rheu-

matic Fever Control of the State Health Department, and the Committee on Rheumatic Fever Control of the new Pennsylvania Heart Association. A joint meeting of these three bodies was held in May. It is apparent that the commission is making a great effort not only to assist the physician with his rheumatic fever and rheumatic heart disease cases but also to educate and alert him and the public to the incidence and seriousness of this problem. The commission is particularly grateful to the county chairmen who have done excellent work in arranging programs. The various rheumatic fever clinics are functioning most satisfactorily. The reference committee highly commends this commission for its accomplishments in a relatively short time. Continuation of the commission is recommended.

Commission on Tuberculosis: The report of this commission shows that two meetings were held during the year—one at Devitt's Camp, Allenwood, in conjunction with the Pennsylvania Chapter of the American College of Chest Physicians, and the other for a review of Chapter K of the survey report entitled "Key-stones of Public Health for Pennsylvania." After reviewing the survey report, the commission passed a resolution recommending that if there is any conversion of children's beds in any of the state sanatoria, it should be for the care of tuberculous patients only. The commission further points out that the large number of patients on the waiting list to be admitted to the sanatoria is at least partially due to inadequacy of pay for all the personnel, as followed by the Bureau of Tuberculosis Control, rather than an actual lack of hospital facilities.

Your reference committee agrees with the members of the Commission on Tuberculosis that the State Health Department should take action to remedy this situation. This is an old problem that receives little attention from year to year. It is one of the gravest of public health problems. This committee would like to suggest that this House of Delegates take action recommending to the proper authorities their desire for immediate correction of the existing conditions. It is believed that the program of the Bureau of Tuberculosis Control in general has good objectives and that the Commission on Tuberculosis can do much to aid in accomplishing these goals. We recommend continuation of the commission.

I recommend adoption of this portion of the report.

SPEAKER BUCKMAN: Is Dr. Engel in the House? [No response.]

The question is on the adoption of this portion of the report which has to do with the reports of the Commission to Study Control of Rheumatic Fever and of the Commission on Tuberculosis. Are you ready for the question?

[Motion was duly seconded and carried.]

DR. CONKLIN: I recommend adoption of the report as a whole.

[EDITOR'S NOTE: The Reference Committee on Scientific Business consisted of the following members: Wendell B. Gordon, Pittsburgh; J. Van S. Donaldson, Butler; Henry B. Kobler, Philadelphia; Constantine P. Faller, Harrisburg; and Stanley D. Conklin, Sayre, chairman.]

[Motion was duly seconded and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. William A. Bradshaw, of Pittsburgh, chairman of the Reference Committee on Hospital Relations.

Report of Reference Committee on Hospital Relations

DR. WILLIAM A. BRADSHAW (Allegheny): Although no serious problems have been reported by the *Committee on Hospital Relations* during the past year, your reference committee feels that the standing Committee on Hospital Relations should be continued. We, therefore, recommend continuance of the committee.

Your reference committee reviewed the report of the *Commission on Mental Hygiene* and wishes to express its wholehearted support of the commission's objectives. We recommend that its report be accepted and that the commission be continued for another year, with sincere thanks for services rendered.

The report of the *Committee on Emergency Disaster Medical Service* was reviewed and we favor the recommendations contained in the committee's report. We should like to suggest that more emphasis be placed upon the transportation problem which would arise in the event of an emergency such as an atomic explosion. This committee recommends that the Committee on Emergency Disaster Medical Service be urged to complete detailed plans as soon as possible in view of the present world situation.

We wholeheartedly recommend the endorsement of the resolution in principle as presented by the chairman of the Committee on Emergency Disaster Medical Service to this House of Delegates on Oct. 16, 1950.

We suggest that the House of Delegates go on record as supporting the appointment of Major General Richard Mellon as Director of Civil Defense in Pennsylvania.

We realize the complications and difficulties which may arise in various communities in the blood-typing program. Because of the lack of detailed information made available to this committee, we recommend that authority be granted to the Committee on Emergency Disaster Medical Service to adopt the means of identification which it feels to be the most practical at the time the program is effectuated.

We recommend continuance of this committee, with thanks for services rendered.

I recommend adoption of this report.

[EDITOR'S NOTE: The Reference Committee on Hospital Relations consisted of the following members: William E. Chamberlain, Philadelphia; Willard C. Masonheimer, Allentown; John F. McCullough, Pittsburgh; Milton F. Manning, Beallsville; M. Louise Gloeckner, Conshohocken; Wilfred W. Wilcox, Montoursville; and William A. Bradshaw, Pittsburgh, chairman.]

[Motion was duly seconded and carried.]

SPEAKER BUCKMAN: Is Dr. Herman A. Fischer ready to report for the Reference Committee on Reports of Officers?

Report of Reference Committee on Reports of Officers (Continued)

DR. HERMAN A. FISCHER: The Board of Trustees recommends that all members entering military service

before June 1, 1951, shall be relieved from payment of 1951 dues. This reference committee approves this recommendation.

The Board of Trustees introduced the following resolution:

Resolution

WHEREAS, The Endowment Fund of the MSSP may be used only on approval of the House of Delegates, in annual meeting assembled; and

WHEREAS, It shall be used "for any purpose devoted to instructional and educational purposes that may be reflected in improved service to humanity under medical auspices; therefore, be it

Resolved, That the 1950 House of Delegates approve the reimbursement of the Society's general checking account in the amount of \$1,000, which amount the Board of Trustees in May, 1950, appropriated to the Society's Commission on Acute Appendicitis Mortality for the purpose of making a survey of certain Pennsylvania hospitals interested in establishing therein "deshocking rooms" with specially trained personnel. In the opinion of the commission, which is confirmed by research in teaching hospitals, establishment of such units would result in much earlier recognition and more effective treatment of approaching shock in a wide variety of medical and surgical conditions.

Your reference committee highly approves and recommends this resolution to this House of Delegates.

I move the adoption of this portion of the report.

[Motion was duly seconded and carried.]

DR. ROY DECK (Lancaster): You spoke about remitting of dues. Is it appropriate to speak about that now?

DR. FISCHER: That is the remission of dues for men entering military service prior to June 1, 1951. They shall be relieved from payment of 1951 dues.

DR. DECK: We have a doctor who recently went to Korea in the World Health Organization. My society asks if he is to be included in this, inasmuch as he didn't have to go into service, is a conscientious objector, a local preacher, and one of our plain sect. I do not believe there will be many, but I believe there will be other World Health Organization men, which is a United Nations organization of health. Would he be included in this?

SPEAKER BUCKMAN: The Chair will divide the report of the reference committee and state the question on the first portion of the report, which is to the effect that all members entering military service before June 1, 1951, shall be relieved of payment of 1951 dues. The question is on the adoption of that portion of the report.

If you wish to include any other individuals or any other classification of national service, now is the time to do it through amendment.

DR. JAMES E. HADLEY (Venango): Does that include the AMA dues and the state society dues, or just the state portion of the dues? Just what does it entail?

SPEAKER BUCKMAN: Dr. Klump, will you answer that?

DR. GEORGE S. KLUMP: This would include all the dues of The Medical Society of the State of Pennsylvania, as I understand it.

DR. DECK: May I present an amendment to that—to include the doctors employed by the United Nations in the World Health Organization?

SPEAKER BUCKMAN: Dr. Deck offers the amendment to include members who are employed in the United

Nations World Health Organization. Do I hear a second?

[The amendment was seconded by Dr. John M. Keichline, Jr., of Huntingdon County.]

SPEAKER BUCKMAN: The question is on the adoption of the amendment to include members who are employed by the World Health Organization. Are you ready for the question?

DR. THOMAS R. GAGION: May I, as a member of the Board who voted for this resolution of the Board, state that this was made for men going into military service. If we start taking in the members of the World Health Organization, missions in Africa, and maybe a lot of other extramilitary things, we will start a string that knows no end. I believe that the sense of the House would be the sense of the Board of Trustees. This is a courtesy to men going into military service prior to June 1, 1951. Thank you!

DR. JOHN M. KEICHLIN, JR. (Huntingdon): I know some of the men who are entering the United Nations' service who are opposed to military life. They are very fine men and did wonderful work in the last World War as non-combatants but working to save our men who were wounded. I think that we have to take due cognizance of these men who are opposed to military life but who are willing to serve their country.

DR. M. LOUISE C. GLOECKNER (Montgomery): I don't think that we can class the group of men who are employed by the United Nations in the same group as those who are employed by denominations as missionaries, however worthy and capable their service may be. It has recently come to my attention that missionaries are not excused from military service in the armed forces, that those who served under the student training program are subject to call for our armed services, and that we would not by any stretch of the imagination be called upon to include those in this kind of an allotment. It seems to me that we are not a political group but that we have no reason not to respect the judgment of the United Nations and the judgment of our military leaders if they are willing to excuse men from military service to serve with the World Health Organization. I would, therefore, favor the motion on the floor.

SPEAKER BUCKMAN: The question is on the adoption of the amendment, and the amendment provides that we would extend to members employed by the United Nations World Health Organization the privilege of remission of dues. Dr. Donaldson!

SECRETARY DONALDSON: I think we should bear in mind that this original motion that our members entering military medical service should be excused from payment of dues in 1951 was intended to make it fit in with the program of county societies and the American Medical Association.

If this amendment should be adopted, I don't believe that we could have any influence on the American Medical Association in asking them to give this conscientious objectors' group the same type of recognition.

DR. CHARLES L. FACKLER (York): After all, these men employed by the WHO are not employed by our government and are not in the service of our govern-

ment. Therefore, I think they should not be included, because I am sure the intent, as Dr. Klump says, of the Board of Trustees was a courtesy to our members who are fostering the service of our government and not the world as a whole or of all the governments of the world. Therefore, I stand opposed to including them.

SPEAKER BUCKMAN: The question is on the adoption of the amendment. Are you ready for the question?

As many as favor the adoption of the amendment, signify by saying, "aye"; contrary-minded, "no." The "noes" have it. The amendment is defeated.

The question now in on the adoption of the report of the reference committee.

DR. WILLIAM BATES (Philadelphia): I didn't go to the reference committee meeting, but it seems to me that the wording—to remit dues for a group of men most of whom will have paid their dues before they go into service—is rather awkward. I think that there is a bookkeeping problem involved that might be answered by stating that any man going into service prior to June 1 shall have credit for those dues when he returns.

DR. JOHN M. KEICHLIN, JR. (Huntingdon): We took care of that in our county society at the last meeting, and if these other county societies are not up to date, that is their fault. [Laughter.]

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's recommendation that our members entering military service before June 1, 1951, should be relieved from payment of 1951 dues. Are you ready for the question?

[Motion was duly seconded and carried.]

The next portion of the report has to do with the transferring of funds from the Endowment Fund to the general checking account of the State Society to repay the general checking account one thousand dollars advanced to the Commission on Acute Appendicitis Mortality. Are you ready for the question?

As many as favor, signify by saying, "aye"; contrary-minded, "no." The "ayes" have it, and this transfer of funds has been authorized.

DR. FISCHER: Dr. Samuel's recommendation that a committee of the House be appointed to study the membership figures has been noted. This reference committee would call the attention of the House to the fact that within the past month a listing of all licensed physicians in Pennsylvania has been made available and suggests that the membership be attacked at the county level. We recommend that this list be provided to each county medical society.

We recommend that his suggestion that a president's page be inserted in the *JOURNAL* be referred to the publication committee of the Board of Trustees for their favorable consideration.

Your reference committee wishes to commend Dr. Samuel for his efforts on behalf of organized medicine in Pennsylvania over a period of years.

I move adoption of this portion of the report.

[Motion was duly seconded and carried.]

Report of the Medical Service Association of Pennsylvania: Your reference committee highly approves

and commends the continued growth and efficiency of the Medical Service Association of Pennsylvania (Blue Shield), and would urge that greater cooperation be given by the individual members of the Society to this organization. We highly approve of their suggestion that every practicing physician be a participating physician, as well as seize every opportunity to acquaint everyone with whom he comes in contact with the values of the voluntary way as the American way.

I move adoption of this portion of the report.

[**EDITOR'S NOTE:** The Reference Committee on Reports of Officers consisted of the following members: Charles L. Shafer, Kingston; Norman C. Ochsenhirt, Pittsburgh; Joseph A. Parrish, Bellefonte; Myer W. Dashe, Reading; and Herman A. Fischer, Wilkes-Barre, chairman.]

[Motion was duly seconded and carried.]

DR. FISCHER: I move adoption of the report as a whole.

SPEAKER BUCKMAN: Dr. Fischer moves the adoption of the report as a whole, which includes those portions accepted at this morning's meeting.

[Motion was duly seconded and carried.]

A few minutes ago, in receiving the report of the reference committee which dealt with the report of the Commission on Tuberculosis, it occurred to the Chair that you might like to hear informally for a few minutes from Dr. Gilson Colby Engel, who is president of the Pennsylvania Health Council.

The Pennsylvania Health Council recently found itself in the midst of a public discussion about the situation in the state sanatoria, and with your permission we will set aside the order of business for a few moments in order to hear informally from Dr. Engel on that discussion.

DR. GILSON COLBY ENGEL: Mr. Speaker, Dr. Samuel, Members of the House: Thank you very much for this courtesy. I just want to take about two minutes and tell you of this tuberculosis situation as far as we know it in the Pennsylvania Health Council.

The Philadelphia County Medical Society released an article, after receiving no satisfaction in Harrisburg or in the Health Department in Philadelphia, charging negligence in the care of tuberculous patients when over 500 active cases are walking the streets of Philadelphia. It then came to the executive committee meeting in Harrisburg of the Pennsylvania Health Council and we issued a press release criticizing the departments for the same thing.

The next thing that happened—we were invited, that is, the Executive Committee of the Pennsylvania Health Council, to Mont Alto to meet Secretary Vaux and his staff at a luncheon. There were, I think, about four or five members of the Health Council who went to Mont Alto and attended that meeting. We first had a delicious luncheon. Then we were taken around to see all the buildings, and they are gorgeous. We then went into a meeting where it was sprung on us, none of us being prepared, that each one of us was to speak. A wire recorder was going to record everything that was said.

Since they were taking wire recordings (I speak of

the State Health Department as they), I took a few notes in quotes, too. One was to the effect that guest editorials in the PENNSYLVANIA MEDICAL JOURNAL were written by people who do not know what they are talking about. The State Society has refused to allow the Secretary of Health to see these editorials before they are printed. That is another quote.

Another quote: Civil service is the poorest excuse for intelligence that I know. That is from the Secretary of Health of the Commonwealth of Pennsylvania.

Another quote: We never requested the survey, as we are supposed to have done.

Gentlemen, I have in my possession carbon copies of the request signed by Dr. Vaux.

The Health Department does have a problem. Their tuberculosis institutions are located in rural communities. The nursing problem is real. As one of the speakers from the Health Council said that day, it really is a socio-economic-marital problem. The nurses have to go a long way, to Chambersburg or to Gettysburg, to keep a date apparently. Those of you who know that country up in through there know it is quite a trip. That poses a real problem in addition to the financial consideration. But they have recently been able to increase the nurses' pay.

The situation of the three hospitals is, briefly, this: At Mont Alto they have 240 beds available now if they had the nurses to man them. At Cresson, they will have 122 beds ready by Nov. 1, 1950, or certainly by July 1, 1951, if they do not have any more labor strikes. At Hamburg, they will have 50 beds ready by Nov. 1, 1950, and by July 1, 1951, they will have another 165 beds ready. Those are the figures on the present situation of available beds.

They have increased the nurses' pay to \$190.50 take-home pay, with fifteen days' vacation and fifteen days' sick leave, with thirteen holidays. The practical nurses are to be paid \$121 per month.

Shortly before our visit the department freely advertised the nurses' increase in pay, but the fact remains that many nurses who are married cannot accept employment so far removed from the towns where their husbands are employed.

It was suggested that the department appoint a committee to survey further this serious problem of insufficient nurses. I personally advised Secretary Vaux to appoint a representative of the department to meet with the Pennsylvania Health Council, which already enjoys such representation from the Departments of Public Assistance and Welfare.

With several questions unanswered, our conference was concluded with the feeling that something worth while had been accomplished and that similar conferences in the future would definitely bring about a better understanding of the department's problems.

SPEAKER BUCKMAN: Year after year so many reports by reference committees are approved by the House of Delegates without discussion that I thought it well to bring to your attention the situation just discussed by Dr. Engel which was not mentioned in the report to the House from the Commission on Tuberculosis.

The Chair was told at the beginning of the meeting that Chairman Walter of the Reference Committee on New Business was not ready. Consequently, we will proceed to the report of the Reference Committee on Amendments to the Constitution and By-laws. Dr. Cornell!

Report of Reference Committee on Amendments to the Constitution and By-laws

DR. WALTER S. CORNELL (Philadelphia): Mr. Speaker, Mr. President, and Members of the House: The Reference Committee on Amendments to the Constitution and By-laws has considered the amendment to the By-laws proposed by the Board of Trustees to delete Section 4 of Chapter IV. Deletion of this section would abolish councilor district meetings so far as the State Society is concerned. It may be remarked that deletion of this section would not interfere with the holding of councilor district meetings by the component county societies of any district on the local initiative of these societies and at their own expense.

Your committee approves the proposed amendment as printed in the June issue of the JOURNAL.

Mr. Chairman, I move adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on the adoption of the proposed amendment to the By-laws which would delete from the By-laws Section 4 of Chapter IV, which reads as follows:

"Each councilor district shall hold one or more district meetings each year for the purpose of increasing acquaintanceship, good fellowship, and organization among the physicians of the district. All physicians residing in the district who are eligible to membership in a component county medical society shall be invited to the meetings."

The effect of the adoption of the proposed amendment is, of course, the discontinuance in the future of councilor district meetings. Are you ready for the question?

As many as favor, signify by saying, "aye"; contrary-minded, "no." The "ayes" have it, and the By-laws have been amended.

DR. CORNELL: Your committee has considered the amendment to Section 3, Chapter IV, of the By-laws, proposed by the Board of Trustees, to include the general public as one of the parties privileged to appeal to the district censors against adverse judgments made at the county society level.

The committee approves the proposed amendment as printed in the June issue of the JOURNAL.

I move adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on inserting in Section 3 of Chapter IV of the By-laws the words "or by the public" as printed in italics in your Transactions. Are you ready for the question?

As many as favor, signify by saying, "aye"; contrary-minded, "no." The "ayes" have it, and the By-laws have been amended in Section 3, Chapter IV.

DR. CORNELL: Your committee has considered the amendment to Section 6, Chapter VII, of the By-laws as proposed by the Lancaster City and County Medical Society. This amendment changes the method of appointment of the Committee to Nominate Delegates to the House of Delegates of the American Medical Association. In effect it provides that the committee be elected by our House of Delegates, that the committee shall be three in number, and that one of the three shall be elected each year to serve for a three-year period.

Your committee approves the proposed amendment as published in the June issue of the JOURNAL.

I move adoption of this report.

[EDITOR'S NOTE: The Reference Committee on Amendments to Constitution and By-laws consisted of the following members: J. Stratton Carpenter, Pottsville; Paul G. Bovard, Tarentum; Jesse G. Fear, Berwick; Willis H. Schimpf, Latrobe; Walter S. Cornell, Philadelphia, chairman; and *ex officio* E. Roger Samuel, Lewis T. Buckman, and Walter F. Donaldson.]

SPEAKER BUCKMAN: The question is on the adoption of the recommendation from the Lancaster City and County Medical Society, amending Chapter VII, Section 6, of the By-laws in accordance with the words italicized on page 2 of your Transactions, which would provide hereafter for the election of a committee by the House of Delegates, a committee to nominate delegates to the American Medical Association. Are you ready for the question?

As many as favor, signify by saying, "aye"; contrary-minded, "no." The "ayes" have it, and that section (Chapter VII, Section 6) of the By-laws has been amended.

That apparently brings us to a report of the Reference Committee on New Business, and except for reports on the supplemental reports which were offered this morning, that would conclude the business of the House, except for the election of the officers. Consequently, it would seem to the Chair that we could adjourn until ten o'clock Wednesday morning. Our experience last year was that after the election of officers we had time to wind up a good bit of business. Unless some of you feel that we can't do it and would need to meet tomorrow afternoon, the Chair will entertain a motion to adjourn the House until ten o'clock Wednesday morning, the day after tomorrow, and the first item of business at the reconvening of the House will be the election of officers.

DR. WILBUR E. FLANNERY (Lawrence): I move that we adjourn until Wednesday morning at ten o'clock.

[The motion was seconded by Dr. Walter S. Cornell, of Philadelphia County.]

SPEAKER BUCKMAN: As many as favor, signify by saying "aye"; contrary-minded, "no."

The House is adjourned until Wednesday morning.

[The meeting adjourned at five o'clock.]

LEWIS T. BUCKMAN, *Speaker*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Wednesday Morning, Oct. 18, 1950

The third and final session of the House of Delegates convened at ten-fifteen o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will please be in order.

The Chair recognizes Dr. Wilson, chairman of the Committee on Credentials.

DR. FRED B. WILSON (Beaver): There is a quorum present.

SPEAKER BUCKMAN: With the permission of the House, we will dispense with the reading of the minutes of the last meeting of the House and proceed immediately to the roll call. Dr. Donaldson!

[Secretary Donaldson called the roll.]

SPEAKER BUCKMAN: Among the tellers appointed at the first meeting was Dr. Pepper who is not active in the delegation seated in the House; consequently, we have substituted Dr. S. Meigs Beyer, of Jefferson County, for Dr. Pepper.

The tellers are Drs. Norman C. Ochsenhirt, Robert L. Schaeffer, and Dr. Beyer.

A total of 132 delegates have responded to roll call.

The Chair wishes to remind you of the outline put in your hands this morning in the form of mimeographed sheets from Dr. Stayer. It was suggested by Colonel Glatty that it might be convenient for you to have this description of the medical officer situation for reference at home and for your own information here (see Appendix B).

The Secretary asks you again to sign the pink slip indicating your attendance at this meeting.

Election of Officers

The next order of business is the election of officers—first, president-elect. The Chair will receive nominations.

DR. JOSEPH W. EHRHART (Luzerne): Mr. Speaker, Members of the House of Delegates: The nomination of a member of this organization for president-elect of The Medical Society of the State of Pennsylvania should take into consideration his merit and recognition of services already rendered to this organization. As first vice-president of the State Medical Society and as a former chairman of its Committee on Medical Economics, his time expended and services rendered are well known to you. It affords me great pleasure at this time to nominate as president-elect Dr. Louis W. Jones.

[The nomination was seconded by Philadelphia, Danphin, Beaver, Montgomery, Allegheny, Cambria, Jefferson, Somerset, Clearfield, and Mercer counties.]

SPEAKER BUCKMAN: Any other nominations?

DR. CHARLES L. FACKLER (York): Mr. Speaker, I move that the nominations be closed.

SPEAKER BUCKMAN: The motion is to close the nominations. As many as favor, which would elect by acclamation, indicate by saying "aye"; contrary-minded,

"no." The "ayes" have it and Dr. Louis W. Jones has been designated your president-elect for 1951.

It is a courteous thing, I suppose, and indicates publicly where support may come, but it is not necessary to second nominations. If you wish to save a few minutes and avoid some confusion, it is not necessary to offer a second to a nomination. The Chair will accept the nomination as announced by the proposer.

The next office to be filled is that of first vice-president.

DR. WILLIAM BATES (Philadelphia): Philadelphia County would like to place in nomination the name of Dr. Theodore R. Fetter.

SPEAKER BUCKMAN: Any other nominations?

DR. GEORGE L. LAVERTY (Dauphin): I move that the nominations be closed.

[The motion was seconded by Dr. Charles L. Shafer, of Luzerne County.]

SPEAKER BUCKMAN: The question is on closing the nominations, which if carried would elect by acclamation Dr. Theodore R. Fetter, of Philadelphia County, to be first vice-president.

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and Dr. Fetter has been elected.

The next office is that of second vice-president. The Chair will entertain nominations.

DR. ELWOOD T. QUINN (Montgomery): I nominate Dr. Alice E. Sheppard, of Pottstown, for second vice-president.

DR. WALTER J. STEIN (Montgomery): I move to close the nominations and elect by acclamation.

[The motion was seconded by Dr. Elmer G. Shelley, of Erie County, and carried.]

SPEAKER BUCKMAN: The next office is that of third vice-president.

DR. WARD O. WILSON (Clearfield): I nominate Dr. Charles I. Shaffer, of Somerset County, for third vice-president.

DR. JOHN W. BARR (Cambria): I move to close the nominations and elect by acclamation.

[The motion was seconded by Dr. David W. Thomas, of Clinton County, and carried.]

[Vice-Speaker Wilbur E. Flannery assumed the Chair.]

VICE-SPEAKER FLANNERY: Nominations for fourth vice-president are now in order.

DR. E. ARTHUR WHITNEY (Delaware): I nominate Dr. LeRoy E. Chapman, of Warren.

VICE-SPEAKER FLANNERY: Any other nominations?

DR. JAMES E. HADLEY (Venango): I move that the nominations be closed.

[The motion was seconded by Dr. Joseph J. Bellas, Mercer County.]

VICE-SPEAKER FLANNERY: All in favor of closing the nominations and thereby electing Dr. LeRoy E. Chapman as fourth vice-president signify by saying "aye." Opposed? The motion is carried.

The next office is that of secretary-treasurer. Do I hear nominations?

DR. ROY W. MOHLER (Philadelphia): I nominate Dr. Walter F. Donaldson.

VICE-SPEAKER FLANNERY: Any further nominations?

DR. CHARLES L. FACKLER (York): I move that the nominations be closed.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County.]

VICE-SPEAKER FLANNERY: It is moved and seconded that nominations for the office of secretary-treasurer be closed, and as Dr. Donaldson is the only nominee, this vote will also elect him.

All those in favor, signify by saying "aye"; opposed? I guess there is no opposition to that.

The next office is that of assistant secretary-treasurer. Nominations are open.

DR. ROY W. MOHLER (Philadelphia): Mr. Chairman, I nominate Dr. Malcolm W. Miller.

VICE-SPEAKER FLANNERY: Any further nominations?

DR. WARD O. WILSON (Clearfield): I move that the nominations be closed.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County.]

VICE-SPEAKER FLANNERY: It has been moved and seconded that the nominations be closed for the office of assistant secretary-treasurer, Dr. Malcolm W. Miller having been named. All those in favor, signify by saying "aye"; opposed, the same sign. The motion is carried and Dr. Malcolm W. Miller is elected to this office.

Next is the office of speaker of the House of Delegates.

DR. CONSTANTINE P. FALLER (Dauphin): I nominate Dr. Lewis T. Buckman.

VICE-SPEAKER FLANNERY: Any further nominations?

DR. HERMAN A. FISCHER (Luzerne): I move that the nominations be closed.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County.]

VICE-SPEAKER FLANNERY: It has been moved and seconded that the nominations be closed. All in favor of closing the nominations and thereby, since there are no other candidates, also carrying with it the election of Dr. Buckman to this office, signify by saying "aye"; opposed, the same sign. The motion is carried.

At this point I would like to find Dr. Buckman. Will he please come back?

[When the speaker and the secretary-treasurer returned to the rostrum, the House arose and applauded.]

SPEAKER BUCKMAN: I take it that Dr. Donaldson has been elected.

SECRETARY DONALDSON: Also Dr. Buckman.

SPEAKER BUCKMAN: The Chair will entertain nominations for the office of vice-speaker.

DR. THOMAS W. MCCREARY (Beaver): I nominate Dr. Wilbur E. Flannery, of Lawrence County.

DR. S. MEIGS BEYER (Jefferson): I move that the nominations be closed.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County.]

SPEAKER BUCKMAN: The question is on closing the nominations and electing by acclamation to the office of vice-speaker Dr. Flannery of Lawrence County. As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and Dr. Flannery has been elected; which brings us to the election of a trustee and councilor for the Third District. The present incumbent is Dr. Francis J. Conahan, who has served one term. The Chair will entertain nominations.

DR. DUDLEY P. WALKER (Northampton): I nominate Dr. Conahan for re-election to the same office.

SPEAKER BUCKMAN: Any other nominations?

DR. WILLIAM A. COGGINS (Lackawanna): I second the nomination.

DR. B. FRANK ROSENBERRY (Carbon): I move that the nominations be closed.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield County, and carried.]

SPEAKER BUCKMAN: The question is on closing the nominations and electing by acclamation Dr. Francis J. Conahan as trustee and councilor for the Third District. As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and Dr. Conahan is elected.

The next office is that of trustee and councilor for the Ninth District. Dr. Frank A. Lorenzo has served two terms and is not eligible for re-election. The Chair will entertain nominations from the floor.

DR. FRANK E. BUTTERS (Venango): I nominate Dr. Daniel H. Bee, of Indiana County.

SPEAKER BUCKMAN: Dr. Daniel H. Bee, of Indiana, is nominated. Any other nominations?

DR. S. MEIGS BEYER (Jefferson): As his nearest neighbor, I would like to second his nomination.

SPEAKER BUCKMAN: Any other nominations?

DR. CHARLES L. FACKLER (York): I move that the nominations be closed.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County.]

SPEAKER BUCKMAN: The question, then, is on closing the nominations and electing by acclamation Dr. Daniel H. Bee as trustee and councilor for the Ninth District. As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and Dr. Bee is elected.

Election of Delegates and Alternates to AMA

The next order of business is to receive the report of the Committee to Nominate Delegates and Alternates to the American Medical Association. The Chair recognizes Dr. David W. Thomas. [No response.] The Chair recognizes Dr. Kech.

DR. AUGUSTUS S. KECH: Mr. Speaker and Mr. President, the committee has considered the members whom we want to nominate as your delegate to the

American Medical Association's House of Delegates. This is probably the last time that such a committee will function, as it has been eliminated by amendment of the By-laws. We are acting this week under the old by-law, which reads:

"It shall be the duty of this committee, after careful consideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor. To conform to the requirements of the House of Delegates of the AMA, each nominee must have been a Fellow in the AMA at least two years prior to his nomination."

We believe that we have recently had the best delegation that has ever represented Pennsylvania in the American Medical Association. These outstanding delegates have taken a very active part in the deliberations of the national body. So the committee has seen fit to nominate them for re-election:

William Bates, Philadelphia

T. Grier Miller, Philadelphia (alternate)

Francis F. Borzell, Philadelphia

Edward L. Bortz, Philadelphia (alternate)

Harold B. Gardner, Pittsburgh

C. L. Palmer, Pittsburgh (alternate)

Charles L. Shafer, Wilkes-Barre

Edgar S. Buyers, Norristown (alternate)

Howard K. Petry, Harrisburg

E. Roger Samuel, Mt. Carmel (alternate)

We asked Dr. Lull whether it is necessary for the Speaker of the House of the American Medical Association to be a member of its House of Delegates. He said yes. We had thought probably we could increase our representation by another delegate and still have Dr. Borzell as Speaker of the House. Dr. Lull told us absolutely that he must be a member of the House of Delegates, so Dr. Borzell has been renominated.

SPEAKER BUCKMAN: Any nominations from the floor?

Will someone move that the report of the committee be accepted, which, if favorable, would carry the election of these nominees?

DR. HAMBLE C. EATON (Dauphin): I move that the report be accepted.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County.]

SPEAKER BUCKMAN: The question is on the adoption of the report of the committee, which would carry with it the election of the names which they have submitted. Are you ready for the question? As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it and these delegates and alternates to the American Medical Association have been elected.

The next item of business is the election of a committee of three to present next year to the House of Delegates their nominations for delegates and alternates to the American Medical Association. It is the suggestion of the Chair that nominations be received and a ballot be had thereon, and that the highest standing

name on the successful list be declared the member for three years on the committee, the next highest be declared the member for two years on the committee, and the third highest ranking one elected be declared the one holding the office for one year on the committee, unless you wish to cast three ballots, one each on a group of nominees for one year, a group of nominees for two years, and a group of nominees for three years.

If I hear no objection from the floor, we will proceed with the election on the first basis. Nominations are now in order.

DR. J. HART TOLAND (Philadelphia): I nominate Dr. David W. Thomas, of Clinton County, as a member of that committee.

DR. E. ARTHUR WHITNEY (Delaware): I nominate Dr. Edgar S. Buyers, of Montgomery County.

DR. CHARLES L. FACKLER (York): I nominate Dr. George L. Laverty, of Dauphin County.

DR. MORGAN D. PERSON (Lehigh): I nominate Dr. Robert L. Schaeffer, of Lehigh County.

DR. RALPH L. COX (Fayette): I nominate Dr. L. Dale Johnson, of Fayette County.

DR. WILLIAM F. BRENNAN (Allegheny): I nominate Dr. William A. Bradshaw, of Allegheny County.

SPEAKER BUCKMAN: Any other nominations?

DR. HERMAN A. FISCHER (Luzerne): I move that the nominations be closed.

[The motion was seconded by Dr. William Bates, of Philadelphia County, and carried.]

SPEAKER BUCKMAN: I direct the tellers to spread the ballot.

Dr. Ochsenhirt is here. Dr. Stein, will you serve as teller in place of Dr. Schaeffer who is one of the nominees?

Each ballot should carry three names. Any ballot which carries more than three or less than three will be disqualified. [Cries of "No, no" from the floor.]

Any ballot containing more than three names will be disqualified.

Will the tellers collect the ballots?

DR. MORGAN D. PERSON (Lehigh): Did you say that we may vote for less than three?

SPEAKER BUCKMAN: I did not, but in response to the overwhelming protest the Chair reversed his ruling and simply announced that a ballot containing more than three names would be invalid.

DR. PERSON: May I ask if there is only one name on, is it still a valid ballot?

SPEAKER BUCKMAN: Yes. The House will be in order.

Dr. Ward O. Wilson, of Clearfield, has appealed from the decision of the Chair. He questions the decision which says that a ballot of less than three names is valid.

As many as sustain the appeal of Dr. Wilson—and that would require, then, a ballot of at least three names—will raise their right hand. As many as do not sustain his appeal will raise their right hand. Dr. Wilson's

appeal is overwhelmingly defeated, and a ballot of less than three names is valid.

Gentlemen, there are 132 registered this morning as seated in the House.

Are all ballots in? I declare the polls closed.

During this interim, the Chair will appoint, as an escort for President-elect Jones, Drs. Charles L. Shafer and Thomas R. Gagion, of Luzerne County.

The tellers are ready, if you wish to follow the voting. [The ballots were tallied.]

SPEAKER BUCKMAN: The House will be in order.

Immediately after the announcement of the vote, we will introduce Dr. Jones and immediately go into new business and election of district censors.

The result of the ballot: Dr. Thomas received 82 votes and is declared elected to the Committee to Nominate Delegates and Alternates to the AMA for a term of three years.

Dr. Buyers received 63 votes and is declared elected to the committee for a term of two years.

Dr. Bradshaw received 59 votes and is declared elected to the committee for one year.

The Chair recognizes Secretary Donaldson.

SECRETARY DONALDSON: I have the list of nominees from the various county medical societies for district censors to be elected. The list is complete, with two exceptions. Elk County has no nominee, and Cumberland County's nominee, Dr. Hershner, died on October 8. We have not received the name of anyone to take his place. If you will consider in nomination the names of nominees for the 58 other county societies to be elected by this House of Delegates as district censors, you will save considerable time that would otherwise be spent in reading these names.

[The nominees for district censors presented by Secretary Donaldson were as follows]: *Adams*, Eugene E. Elgin; *Allegheny*, David P. McCune, Sr.; *Armstrong*, James F. Allison; *Beaver*, Jesse H. Swick, II; *Bedford*, John A. Topper; *Berks*, Leon C. Darrah; *Blair*, James W. Hersherberger; *Bradford*, Willis A. Redding; *Bucks*, Allen H. Moore; *Butler*, Earle L. Mortimer; *Cambria*, William L. Hughes; *Carbon*, Clinton J. Kistler; *Centre*, Joseph A. Parrish; *Chester*, William Limberger; *Clarion*, Edward J. Keeling; *Clearfield*, Blair G. Learn; *Clinton*, William C. Long, Jr.; *Columbia*, Jacob L. Gluchoff; *Crawford*, John H. Bailey; *Cumberland*, Newton W. Hershner*; *Dauphin*, Norman B. Shepler; *Delaware*, John B. Klopp; *Elk*, ...; *Eric*, Elmer G. Shelley; *Fayette*, Othello S. Kough; *Franklin*, Frank J. Corbett; *Greene*, Bruce R. Austin; *Huntingdon*, Frederic H. Steele; *Indiana*, Ralph G. Ellis; *Jefferson*, Hollister W. Lyon; *Juniata*, Stephen I. Dodd; *Lackawanna*, William A. Coggins; *Lancaster*, Mahlon H. Yoder; *Lawrence*, Paris A. Shoaff; *Lebanon*, John D. Boger; *Lehigh*, John J. Hennemuth; *Luzerne*, Lachlan M. Cattanaach; *Lycoming*, Albert F. Hardt; *McKean*, Cletus B. Walker; *Mercer*, Clarence C. Campman; *Mifflin*, Raymond R. Decker; *Monroe*, William R. Levering; *Montgomery*, Elmer R. Place; *Montour*, James A. Collins, Jr.; *Northampton*, Clinton F. Stofflet; *Northumberland*, Henry F. Ulrich; *Perry*,

* Deceased Oct. 8, 1950.

Blaine F. Bartho; *Philadelphia*, Hugh Robertson; *Potter*, Herman C. Mosch; *Schuylkill*, Francis M. Dougherty; *Somerset*, Charles J. Hemminger; *Susquehanna*, James J. Grace; *Tioga*, D. Elvio Lewis; *Venango*, Charles S. Bridenbaugh; *Warren*, Jacob F. Crane; *Washington*, Paul P. Riggle; *Wayne-Pike*, Louis B. Nielsen; *Westmoreland*, D. Ray Murdock; *Wyoming*, John J. Foote; *York*, Charles L. Fackler.

DR. PERSIS S. ROBBINS (McKean): I move that the nominees for district censor as reported to the Secretary's office be declared elected for the year 1951.

[The motion was seconded by Dr. Eleanor Larson, of Tioga County.]

SPEAKER BUCKMAN: As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and this list is declared elected as the district censors.

The Chair recognizes Dr. Gagon and Dr. Shafer.

[Drs. Gagon and Shafer escorted President-elect Jones to the platform. The audience arose and applauded.]

SPEAKER BUCKMAN: Ladies and gentlemen of the House, of necessity I have known Dr. Jones at home for a great many years. I can vouch for him as a good friend and citizen, having observed his work in our home county society for a number of years. I had a little part in introducing him to the work of The Medical Society of the State of Pennsylvania. He has justified my every hope. He has proved to be an excellent worker, and you have all become well acquainted with him through his efforts in your behalf. You have done him a great kindness and honor by electing him to this office, and I assure you, you have not made a mistake.

Dr. Louis W. Jones, your president-elect!

PRESIDENT-ELECT LOUIS W. JONES: Mr. Speaker, Mr. President, Mr. Secretary-Treasurer, Ladies and Gentlemen of the House of Delegates: I deeply appreciate the honor that this House has extended to me today. To say that I am overwhelmed by surprise would be untrue, because I had heard rumors that I might be a candidate for this office.

To say that I am entirely unfamiliar with the responsibilities of this office would likewise be untrue because I have been privileged to attend the meetings of this House of Delegates for some years as well as all meetings of the Board of Trustees.

Even as I am overjoyed at being selected by this House to this office, there comes to me a great note of sadness. One of the members of Luzerne County, one of my dear friends who last night received his certificate at the graduate education ceremonial, died of a heart attack last night on his way home to Wilkes-Barre—Dr. Almon C. Hazlett.

I realize my deficiencies and shortcomings as a leader. I realize it will be extremely difficult to fill the shoes of a Buckman, a Bates, an Estes, a Hess, a Petry, an Engel, a Samuel, or a Gardner; but I pledge to this House of Delegates that I will devote my untiring efforts to keep the banner of organized medicine in Pennsylvania floating fearlessly over a free America.

SPEAKER BUCKMAN: The next order of business is new business. The Chair recognizes the chairman of

the Reference Committee on New Business, Henry Walter, Jr.

Report of Reference Committee on New Business

DR. HENRY WALTER, JR. (Lancaster): Mr. Speaker, Members of the House: The reference committee consisted of five members, but only four are present, one member being absent from all the sessions—Dr. Urbaitis. I presume he is not here.

Your reference committee wishes to make the following report:

Commission on Preventive Medicine and Public Health: This commission has apparently spent a tremendous amount of time in its activities with resulting benefit to the further solution of health problems in the State of Pennsylvania. The scope of the activities of this committee is so great and its progress so evident that we conclude that the real benefit of its activity has not yet been adequately measured.

We would point out that in the supplemental report, under Item I, the commission has proposed that no legislation concerning the survey "Keystones of Public Health for Pennsylvania" be introduced by The Medical Society of the State of Pennsylvania until the research project is completed by the law schools of the University of Pennsylvania and the University of Pittsburgh. However, your committee would also point out that it is possible that legislation might be introduced from sources other than ours which would call for adequate action by our Committee on Public Health Legislation and that such action would of necessity be acceptable to our Board of Trustees.

We recommend continuation of this commission and commend it for its excellent activity.

I move adoption of this portion of the report with the interpretation.

[Motion was duly seconded and carried.]

Committee to Study Recommendations of Past President Gilson Colby Engel: Your reference committee will present its review of the above committee's report in three parts. We would ask permission to present the entire report and the several portions can be considered separately, if desirable.

1. The committee to study Dr. Engel's report recommends the establishment of a disease control committee consisting of 20 chairmen of commissions and committees having to do with health problems. The membership also includes the secretary-treasurer of The Medical Society of the State of Pennsylvania and a physician who is connected with the State Health Department. It is proposed that this disease control committee be headed by the president of The Medical Society of the State of Pennsylvania. The committee would meet twice yearly. Its function would be to study and coordinate the activities of the component groups.

Your reference committee wishes to point out that the quantity of secretarial work done by the State Medical Society would obviously be increased as the result of the creation of such a committee.

After having had many interviews, we feel doubtful of the efficiency of such a large committee. However, many who would be involved at the present time in

such a committee feel that the proposal has merit and we believe that this portion of the report should be adopted with the following amendments:

- (a) The president shall delegate the president-elect to preside over the disease control committee.
- (b) The committee shall be appointed to serve for one year.

2. This portion of the report recommends the establishment of a policy coordinating committee consisting of the chairman of the Public Health Legislation Committee, chairman of the Public Relations Committee, and chairman of the Medical Economics Committee, and includes the secretary-treasurer, the committee to be presided over by the president of The Medical Society of the State of Pennsylvania.

The committee would coordinate and study the activities of the various committees involved.

We feel that the activities of the Public Health Legislation Committee must often be the result of spot decisions subject to reversal overnight at the discretion of the chairman as a result of legislative procedure. To a certain extent, complete coordination of these committees is impossible. Nevertheless, we recommend adoption of this portion of the committee report with the following amendments:

- (a) That we strike the word "policy" from the name of the committee, for we feel that policy establishment is the function of the House of Delegates, the Board of Trustees in the interim, and that this committee should be named instead "The Coordinating Committee."
- (b) That the committee be appointed for a period of one year.

3. We further recommend that the committee to study the recommendations of Past President Gilson Colby Engel be continued and that this committee study the results obtained by the creation of both new committees and report to the House of Delegates at the end of the year on the advisability of continuing these two new committees.

I move the adoption of the entire report of the committee as amended and the recommendation of the reference committee.

SPEAKER BUCKMAN: The Speaker will divide the question, without objection. The first question is on the acceptance of the reference committee's report relative to the establishment of a disease control committee, with the amendment of the reference committee that the president-elect shall preside over the meetings and activities of this committee, and with the further amendment that the committee be appointed to serve for one year. Are you ready for the question?

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and this portion of the report is adopted.

The second question is on the adoption of the report which recommends the establishment of a coordinating committee and eliminating the word "policy," as recommended by the committee that studied Dr. Engel's report, and with the further provision that this committee have a life of one year.

Are you ready for the question? As many as favor,

signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and this portion of the report is adopted.

The third question is on the adoption of that portion of the reference committee's report which moves the continuation of the committee to study the recommendations of Past President Gilson Colby Engel.

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and this portion of the report is adopted.

Report on the Resolution from the Philadelphia County Medical Society: This resolution (1) disapproves the plan of the American Hospital Association to establish a hospital standardization program; (2) recommends that the new hospital standardization program be a joint venture whereby: (a) medical components of the plan would set medical practice standards; (b) administrative components of this plan would set non-medical standards, and each group would be equally represented on the board.

The substance of this resolution is that it be presented to the House of Delegates of the American Medical Association at Cleveland in December, 1950, by the delegation of The Medical Society of the State of Pennsylvania.

I move the adoption of this resolution.

SPEAKER BUCKMAN: The question is on adoption of this portion of the reference committee's report having to do with the resolutions from the Philadelphia County Medical Society. Are you ready for the question?

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and this portion of the report is adopted.

Resolution from Philadelphia County Medical Society Concerning First-Class Mail Deliveries: This resolution proposes that the House of Delegates go on record as urging the prompt restoration of previous first-class mail deliveries and collection schedules.

We move that this resolution be not adopted.

SPEAKER BUCKMAN: The question is on adoption of the resolution from the Philadelphia County Medical Society relative to first-class mail deliveries, notwithstanding the report of the reference committee. A favorable vote would accept the report of the reference committee and make no complaint about first-class mail deliveries. An unfavorable or negative vote would reject the recommendation of the reference committee and would accept the resolution of the Philadelphia County Medical Society. Is that understood?

As many as favor, signify by saying "aye"; contrary-minded, "no."

As many as favor will raise their right hand.

Dr. Gagon, do you have a question?

DR. THOMAS R. GAGON: I wanted a voice in the discussion; that is all.

SPEAKER BUCKMAN: Dr. Gagon asks for the floor.

DR. GAGON: Will you please give this some consideration as to its importance in public relations? The union of postal employees is a very strong union. If we adopt a resolution that not only would improve our mail service but might bring into our camp a strong union such as the postal employees union is, it would give us

an ally in the labor ranks, and we need all the allies we can get.

If the reference committee has some good reasons for not adopting the resolution, perhaps the House may like to know them. But from the standpoint of public relations, I would urge that we think over whether we want to reject this resolution or not.

DR. JOSEPH J. TOLAND, JR. (Philadelphia): Mr. Chairman, I would like to explain just what this is. First-class mail is bearing the brunt at the present time. They did cut the appropriations in Washington and it was intended really to apply to second- and third-class mail—newspapers, magazines, and so forth; but instead of that, the government has taken the money out of the first-class mail deliveries. You can read in the papers every day complaints about three or four days being required for a special delivery letter being sent from Atlantic City to Philadelphia, for instance.

Doctors need first-class mail promptly and there should be no cut in this first-class mail delivery. The postal employees are with us on that. I think we should all vote no on this resolution.

SPEAKER BUCKMAN: I beg your pardon, Dr. Toland. You do not mean to vote no to the resolution?

DR. TOLAND: The reference committee's resolution, that we vote against it. Isn't that what is on the floor?

SPEAKER BUCKMAN: The question is on the rejection of the recommendation of the reference committee and the acceptance of the resolution of the Philadelphia County Medical Society. An affirmative vote will accept the resolution of the Philadelphia County Medical Society.

[Cries of "No, no" from the audience.]

SPEAKER BUCKMAN: Yes.

The Chair recognizes Dr. Walter.

DR. WALTER: Concerning this resolution, I would like to say that no one appeared before the reference committee to talk about it. We came to our own conclusions as a result of our own thought on the matter. That is all we were privileged to consider. The feeling that we had about it was not expressed to us as it was put on the floor today. I suspect the reference committee might have changed its mind had it heard some of these expressions.

I would say in defense of the reference committee's position that the Hoover Report recommended cutting expenses; that from our point of view, and without considering any of these facts which were brought out, we felt that we were going on record as helping or making an attempt to decrease expenses, and we did not feel that we would be exactly in a position to interfere in such a procedure as a House of Delegates.

DR. WENDELL B. GORDON (Allegheny): The Hoover Commission did not recommend reducing first-class mail deliveries to cut expenditures. They recommended many other reforms which have not been adopted by Congress, but that wasn't one of their recommendations.

DR. GEORGE L. LAVERTY (Dauphin): I feel that this is a vital fundamental issue to us as physicians, because in the course of our daily lives we are complaining about paying taxes and we are complaining about the

interference with the operation of our business. It just seems to me that we would be interfering with the operation of government business, a business that is definitely a government function.

Is the question one of complaining about the particular over-all problem of appropriating more money, or should our complaint be on the method in which the effort has been made to try to cut expenses? I rather favor the opinion of the committee or the conclusion they have come to in the report they have made. I feel as though we shouldn't just go along with the current in trying to improve public relations, as Dr. Gagon said; we shouldn't expect to spend more government money to promote our own public relations.

SPEAKER BUCKMAN: The Chair recognizes Dr. Donaldson.

SECRETARY DONALDSON: I had no intention of speaking on this subject. I am not positive that the Hoover Commission did not specify reduction of expenses in the Post Office Department. Dr. Gordon may know better about that than I do. But there has been no doubt in my mind since this ruling went into effect that the Administration at Washington reduced expenses on this particular item, which reaches into every household and every office, to make more and more unpopular the reduction of any governmental expenditures.

DR. WILLIAM BATES (Philadelphia): I apologize to the House for speaking on this, because we presented it from Philadelphia and I did not appear before the committee because I was unavoidably detained yesterday. But I take exception, for the first time, I think, with Dr. Laverty when he says that we have no right to interfere with government. We are the government. I think we have all the right in the world, not only as doctors but as citizens, to express our feelings on these matters. The Congressmen want an expression and we are trying to give it to them. Just because it is government, it is not too sacred for us to handle.

DR. WALTER S. CORNELL (Philadelphia): I just want to say to the members who live in smaller communities where possibly this isn't a live issue that at my residence in Philadelphia, the mail used to be delivered about a quarter to nine in the morning. Now, it is delivered at one o'clock in the afternoon, with the result that any mail that comes to me on Tuesday, I read Tuesday night.

DR. MORGAN D. PERSON (Lehigh): I might say that it is of importance to us in the rural districts because we get a lot of reports from laboratories in Philadelphia, and even Pittsburgh, and it delays the mail sometimes as much as three days. We get a diabetic report three days later and it is of vital importance in many cases.

SPEAKER BUCKMAN: There was a storm of protest a moment ago at the form in which the Chair stated the question. I am going to read for your information a part of paragraph 54 from Robert's Rules of Order, headed "Adoption or Acceptance of Reports." It says there if the recommendation, that is, the recommendation of the reporting committee, is that the resolution be not adopted, the question on the resolution when it is put should be stated thus: "The question is on the

adoption of the resolution," the recommendation of the committee to the contrary notwithstanding.

That means that the question now is on the adoption of the Philadelphia report, contrary to the recommendation of the committee. An affirmative vote, then, will adopt the resolution of the Philadelphia County Society.

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it. The resolution from the Philadelphia County Medical Society is adopted.

Request for Consideration of School Health Examining Act Administration by the Commission on Preventive Medicine and Public Health introduced by Dr. Palmer, member of the House of Delegates, at the request of the Department of Health of the City of Pittsburgh: After due consultation and consideration, your reference committee feels that it has not been able to become sufficiently acquainted with the facts underlying this request and that such an investigation could conceivably involve the expenditures of large sums of money by The Medical Society of the State of Pennsylvania.

We therefore recommend that this request be referred to the Board of Trustees for consideration.

I move the adoption of this portion of the report.

SPEAKER BUCKMAN: The question is on referring this portion of the report to the Board of Trustees.

[The motion was seconded and carried, referring this portion of the report to the Board of Trustees.]

Supplemental Report from the Committee on Procurement and Assignment: This report goes into detail concerning methods of classification, procurement and assignment of physicians for the armed forces, and its utilization of component county medical society procurement and assignment committees to aid it in its work.

We commend the committee for the great progress it has made. The Medical Society of the State of Pennsylvania is fortunate in having Dr. Stayer as chairman of this committee with an experience of over forty years as an army medical officer.

We feel that The Medical Society of the State of Pennsylvania should go on record as expressing the feeling that this committee should be the final agency in advising the armed forces on procurement and assignment of physicians in Pennsylvania.

I move the acceptance of the committee report and the adoption of the reference committee recommendations.

SPEAKER BUCKMAN: There was distributed this morning a statement from General Stayer and from Colonel Glattly. Dr. Stayer has entered the House and perhaps at this time he would like to say a few words amplifying the statement which was distributed. Dr. Stayer!

DR. STAYER: I thought perhaps you would want to take this prepared statement home, since there will be many questions asked of you; also, our telephone is always handy and we are glad to answer any questions as long as the committee is permitted to serve.

SPEAKER BUCKMAN: Thank you.

The question is on the adoption of this portion of the reference committee's report.

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and this portion of the report is adopted.

Report of Committee on Military Affairs: This committee reports no activity during the year. Many of its recommendations concerning further activity are now being carried out by the Committee on Procurement and Assignment.

We recommend that this committee continue in its assigned duty to act as liaison agent between this society and the office of the Secretary of Defense.

I move the adoption of this portion of the report.

[Motion was duly seconded and carried.]

Commission on Acute Appendicitis Mortality: This commission has continued its active program throughout the year. The remarkable progress in reducing mortality from appendicitis in Pennsylvania over the last decade is evidence of the good this commission has done.

We recommend that the report of the commission, with its recommendations, be accepted.

[Motion was duly seconded and carried.]

Supplemental Report of Commission on Defense of Medical Research: This report recommends changing the title of the commission to "Commission on Promotion of Medical Research."

I move the adoption of the report of this commission.

[Motion duly seconded and carried.]

DR. WALTER: I move the adoption of the report of the reference committee as a whole.

[EDITOR'S NOTE: The Reference Committee on New Business consisted of the following members: Joseph F. Dunn, Chester; Arthur Miltenberger, Johnstown; Michael Margolies, Coatesville; and Henry Walter, Jr., Lancaster, chairman.]

DR. GAGION: As amended or as a whole?

SPEAKER BUCKMAN: As a whole and as amended. The question is on the adoption of the amended report as a whole, with the exclusion of that portion which was defeated, of course.

[Motion was duly seconded and carried.]

SPEAKER BUCKMAN: Is Dr. Bradshaw in the House? Dr. Bradshaw is chairman of the Reference Committee on Hospital Relations. Do you have a report on the supplemental report submitted Monday? [No response.] In that event, I will ask the House to consider it informally.

Will someone move that we discharge the committee from consideration of the supplemental report of the Committee on Emergency Disaster Medical Service?

DR. FRANK E. BUTTERS (Venango): I so move.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield County, and carried.]

SPEAKER BUCKMAN: Any discussion on the question? As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it, and we now enter into informal discussion or consideration of the supplemental report.

I asked this for the following reason—you may correct me, but I think no action has been taken on it: In the supplemental report which was submitted and dis-

tributed on Monday, the committee, under the chairmanship of Dr. Fetter, recommended: "We should like to ask the cooperation of this House of Delegates in requesting each county medical society to prepare itself by the appointment of a committee," which means a Committee on Emergency Disaster Medical Service.

Acceptance of this report, then, would carry with it the recommendation of the House to each county medical society that it establish such a committee. May I ask for a motion to accept the report?

DR. EDGAR S. BUYERS (Montgomery): I so move.

[The motion was seconded by Dr. Walter J. Stein, of Montgomery County, and carried.]

SPEAKER BUCKMAN: Dr. Joseph Toland, three supplemental reports were referred to your committee.

Report of Reference Committee on Reports of Commissions (Continued)

DR. JOSEPH J. TOLAND, JR. (Philadelphia): We recommend that the supplemental report of the *Commission on Graduate Education* be approved.

[Motion was duly seconded and carried.]

Supplemental Report of Commission on Physical Medicine and Rehabilitation: This subject probably is becoming more important every day and this committee has been working mighty hard in every way to bring physical medicine and rehabilitation to the foreground. They have done an excellent job and we recommend that their supplemental report be approved.

[Motion was duly seconded and carried.]

Advisory Committee to Pennsylvania Board for Vocational Education: Your committee recommended that this report be received, and since the purpose of the committee had been fulfilled, we recommended that it be discharged with thanks. Since then, we have received additional information.

I move that our recommendation be reconsidered by this House.

SPEAKER BUCKMAN: The question is on reconsidering the action by the House on Monday in approving the reference committee's recommendation to discharge the Advisory Committee to the Board for Vocational Education. It will require a two-thirds vote.

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it. The vote is reconsidered.

DR. TOLAND: We have asked that our recommendation be reconsidered. We further ask that this committee, being an advisory committee to the Pennsylvania Board for Vocational Education, as appointed by the Board of Trustees, be thanked for completing the work that was assigned them and that the committee be continued.

[Motion was duly seconded and carried.]

SPEAKER BUCKMAN: A proposed amendment to the Constitution has been brought to the desk, properly signed by 16 members of the State Society. I will read it for the record, and it will be submitted to the Secretary's office to be published in due course for action next year:

ARTICLE V.—HOUSE OF DELEGATES—shall be amended by adding at the end of the first sentence of the first

paragraph the words: "except as provided in the third paragraph of this article."

ARTICLE V.—HOUSE OF DELEGATES—shall be amended by adding a new paragraph, to wit:

"Any other officer having the right to sit in the House of Delegates in an ex officio capacity as defined in the first paragraph of this article, if elected by his county society as an active delegate, accredited to the House, and seated as such, shall not be deprived of his vote by reason of his prior ex officio right, but shall be entitled to vote as an elected delegate at the session to which he has been elected."

The Chair recognizes the chairman of the Board of Trustees, Dr. Klump.

DR. KLUMP: This is in relation to 1951 dues, and I would like to defer to the chairman of the Finance Committee.

SPEAKER BUCKMAN: The Chair recognizes Dr. Whitehill.

DR. JAMES L. WHITEHILL: At the July meeting of your Board of Trustees its Finance Committee was given the responsibility of making an adequately wide study of the income and the administrative expenditures of not only our own state medical society but of other state societies closely related to our own society in size and in purposes and aspirations. The Finance Committee, therefore, devoted considerable time to the exploration of sources of income as well as the avenues of outgo of the funds of our own society. If you have had respect for the management of the funds of our society by your Board of Trustees in recent years, you may agree that such management in the past has been reasonably good and obviously effective on the basis of the annual financial report of the Secretary-Treasurer to this House of Delegates as published each year in the September issue of the PENNSYLVANIA MEDICAL JOURNAL and distributed to the delegates in the printed transactions at the beginning of each annual session.

We not only explored as deeply as possible the receipts and expenditures of our own society but we studied reports supplied to us by the proper officers of such other state societies as California, Illinois, Michigan, and Ohio.

In order to meet our own fiscal situation for the coming year, our Finance Committee made recommendations to the Board of Trustees during this session that included certain reductions in the budget provided for the Society's administrative policies and for the activities of some of the Society's most active committees. Our Board of Trustees has devoted two entire periods during this convention to the consideration of the Finance Committee's recommendations, and only at the end of the second three- or four-hour period did the Board arrive at the following conclusion:

If our organization is to be adequately financed to meet not only the curtailed expenditures above referred to and at all times to maintain a surplus sufficient to safely meet unexpected contingencies which may develop during the current disturbing world wide economic and political relations, then we should have the additional income which may be developed by setting the active

membership dues for the year 1951 at \$25, with \$1.00 allotted to the Benevolence Fund, \$2.00 to the Educational Fund, and \$22 to the General Fund.

This proposal was reached after long and free discussion by the Board members with two dissenting votes.

This is respectfully submitted in the name of the Board of Trustees by the Finance Committee (James Z. Appel, Herman H. Walker, and James L. Whitehill, chairman).

SPEAKER BUCKMAN: The question is on the adoption of the report from the Board of Trustees establishing the dues for next year at \$25 with \$1.00 to be allotted to the Benevolence Fund, \$2.00 to the Educational Fund, and \$22 to the General Fund. Are you ready for the question?

As many as favor, signify by saying "aye"; contrary-minded, "no." The "ayes" have it. The report is accepted, and the dues are established for 1951 at \$25.

Is there any other item of new business? Or is there any resolution or recommendation previously submitted?

DR. JOSEPH J. BELLAS (Mercer): Mr. Speaker, Mercer County has a few things to bring before the House of Delegates of The Medical Society of the State of Pennsylvania.

First, the MSAP. Our state medical society established insured medical service now known as Blue Shield. More recently, Blue Shield established non-group participating insurance. In our locality we were asked to try to procure applicants for this insurance. In my office I was associated with an insurance company whose district headquarters is in Sharon. They have 15 agents and they are not interested in this particular type of insurance—Blue Shield and Blue Cross. However, their 15 agents carried these cards when they were selling insurance and if their applicants requested information in reference to Blue Cross and Blue Shield, or health insurance, they gave them these cards, which were sent, I think, to the office in New Castle. Months have passed and no replies have been received.

We want to bring that to the attention of the proper committee. We want it spread upon the minutes and properly dealt with.

Recently, you will recall, the Veterans Administration had to cut down on expenses and the number of visits that the applicant was receiving from the Veterans Administration and the local physician. He was then allowed only one visit a month. Many of these patients had to be examined. There were seven forms to fill out and not infrequently seven or eight prescriptions given, and for that work we received the great sum of \$2.00. You fill seven prescriptions and on each prescription you write, "I hereby certify that I have been authorized by the Veterans Administration to take care of this patient." Seven of them and then seven forms! For that we feel there is a form like the dentists have in the Veterans Administration, wherein they get the authorization. The dentist signs this form and sends it back, and there are no other forms to fill out.

We wish the attention of the Committee on Veterans Administration to be called to this matter.

We find that the Public Assistance Department has already requested that we reduce or do something about the cost of public assistance. In our particular area, if

the Public Assistance Department agents would investigate the cases themselves, they could cut down on their expenses at least 50 per cent. I know of two cases; one is a woman on public assistance who leaves our community in May and does not return until October. She goes to Atlantic City and works for the sum of \$65 to \$80 a week, and during that time her daughter receives her checks for public assistance, and when she returns in October she continues to receive them.

There are others who are receiving public assistance, such as mothers' assistance. They are supposed to be grass widows or divorcees, but I find a number of them are living with their husbands and their husbands are working. They are going out and doing house work, also some home work. When it is called to their attention, they say, "Well, someone might squeal on them." If they do, it will be 50 per cent of the people around there that are receiving public assistance who will be taken off the assistance.

When that is reported to the manager of Public Assistance, he says, "Well, who are they?"

I say, "Well, I am not a policeman. You have 18 or 20 investigators here and, if they are doing their duty, you shouldn't have any trouble in finding them out."

I move that these matters be referred to the proper committees.

SPEAKER BUCKMAN: The question on the individual contracts under medical service will be referred to the Board of Directors of the Medical Service Association of Pennsylvania which meet this afternoon.

The question about veterans' forms will be referred to the Committee on Medical Economics.

The question on dishonesty among the recipients of public assistance will be referred to the State Healing Arts Advisory Committee.

Is there anything else to be brought before the House?

DR. WILLIAM BATES (Philadelphia): Mr. Speaker, it is customary, I believe, as the session draws to an end, for the county society acting as host for the session to express its pleasure at having had the session here and to extend the invitation again two years hence. We hope that nothing will interfere with the schedule, and we will try to make you happy when you return.

DR. THOMAS R. GAGION: Mr. Speaker, may I have my annual privilege of suggesting that this House rise in a vote as a token of appreciation to the host county society which has given us a very, very splendid convention. I suggest that the House do it. I don't have the privilege of making a motion.

SPEAKER BUCKMAN: The House will rise and express its appreciation to the Philadelphia County Medical Society.

[The audience arose and applauded.]

SPEAKER BUCKMAN: The House will please be seated.

The Chair recognizes Secretary Donaldson.

SECRETARY DONALDSON: Mr. Speaker and Members of the House: I have before me a formal invitation from the Allegheny County Medical Society confirming its verbal invitation of one year ago that you come to Pittsburgh in 1951. I don't think it requires any action.

I want to give you a brief report on the registration.

Up to last evening, Tuesday, the end of the second day, 1472 of our own members had registered, with 305 guest physicians. These are non-members from Pennsylvania, New York, New Jersey, and Maryland who have been invited to come and have been told that there is no registration fee. The total registration will appear in detail in the December PENNSYLVANIA MEDICAL JOURNAL.

SPEAKER BUCKMAN: Is there any other matter of business or any announcement to be made to the House?

SECRETARY DONALDSON: If Dr. Bee, newly elected trustee and councilor, is in the House, he is invited to meet with that board at its next regular meeting at one o'clock.

SPEAKER BUCKMAN: We will entertain a motion to adjourn the House sine die.

DR. WARD O. WILSON (Clearfield): I so move.

[The motion was seconded by many members.]

SPEAKER BUCKMAN: The House is adjourned.

[The final session of the House of Delegates adjourned at twelve forty-five o'clock.]

LEWIS T. BUCKMAN, *Speaker*,

WALTER F. DONALDSON, *Secretary-Treasurer*,

WILBUR E. FLANNERY, *Vice-Speaker*.

APPENDIX A

Report of Medical Service Association of Pennsylvania

To the President and House of Delegates:

It is a distinct pleasure, as well as a privilege, to report to you again this year concerning the ever-expanding community service provided by the Pennsylvania Blue Shield Plan to a constantly growing number of persons.

Ten years ago the Medical Service Association of Pennsylvania came into being because of the interest and loyal support of the medical profession. Today, the height of success which it now holds would not have been attained if that support and interest had not continued and grown.

The fruits of this support are seen not only in the growing membership, which we are able to report each month, but also in the large number of letters we receive from members expressing appreciation for their doctors who told them about the values of Blue Shield health protection.

Our Growth in Ten Years of Community Service

During the past year MSAP observed the tenth anniversary of its founding on April 3, 1940. Only a few days ago, on October 1 to be exact, the first decade of enrollment activity in the association was completed. In the first three months of signing subscribers in Pittsburgh back in 1940, only 967 members were obtained. During World War II years, growth was very slow so that the association had only 26,740 subscribers at the end of five years, most of them in the western part of the State. In the next four years, membership grew to 556,693 by Dec. 31, 1949.

Today, Blue Shield protection is provided to 800,000

Pennsylvanians, from every one of the 67 counties of the State.

In 1940 only 144 physicians were "participating doctors" of the Medical Service Association. Today, there are 7917 doctors of medicine, 464 doctors of osteopathy, and 251 doctors of dental surgery, a total of 8632 participating doctors. The growth in participating doctors during the past year alone has been 649, which represents an increase of 8 per cent over this time last year.

Progress Continued During Past Year

In the year from July 31, 1949, to July 31, 1950, 278,304 subscribers were added to the membership of the Pennsylvania Blue Shield Plan. This represented an increase of 60.3 per cent, and brought the total number of subscribers to 740,103 at the end of July.

In 1949 doctors were paid \$1,481,548 during the first seven months, while during the same period of this year payments to doctors amounted to \$2,554,851. This was an increase of \$1,073,303, or 72.4 per cent. Doctors' service reports paid during the initial seven months of this year numbered 41,901, an increase of 15,286, or 57.4 per cent, over those paid during the same period of last year.

A year ago I reported to you that we had just begun to offer a non-group agreement to the public, under which individuals might obtain the protection of Blue Shield. The Board of Directors, which had been considering non-group enrollment for some time, had no way of predicting the popularity of this type of agreement. The fact that 37,381 subscribers enrolled on a non-group basis during the first ten months that this plan was in operation indicates that an important need is being met.

Non-group enrollment now is open throughout the State to anyone in good health under 66 years of age. Special promotion efforts to secure enrollment in this type of agreement will be conducted during February, May, August, and November of each year.

Providing a practical, workable plan of voluntary, prepaid medical care for *all* the people of Pennsylvania has been the constant aim of the officers, directors, and staff of the association. Frequent studies are made to discover possibilities for new benefits and greater service to subscribers. In doing this we are adhering to the mandate of the 1938 House of Delegates and of the Legislative Act of 1939. At the same time, it is essential that we keep in mind that any increase of benefits for subscribers must also be acceptable to our participating doctors, who are so important to the continued success of the association.

It is with considerable pride, therefore, that I report to you two important changes in benefits made within the last year, both of which have been enthusiastically received by subscribers, of value in enrollment efforts and acceptable to participating doctors.

"Service" Feature of Plan Changed

You may remember that in my report at the 1949 House of Delegates meeting, I dwelt at some length on the need for maintaining our Blue Shield Plan as a "service plan" of prepaid medical care for low-income groups. First steps already had been taken by that time to permit the changing of the MSAP income limits to

conform with economic conditions of the day and thus restore the "service" feature of our agreements.

Committees of the State Society's trustees and of MSAP's Board of Directors were meeting a year ago to determine a new definition of income limits, as permitted by the change made in the Legislative Act of the 1949 General Assembly and by a change in the corporation's by-laws. Their recommendations for modification of the definition were approved by members of the corporation, the Board of Trustees of The Medical Society of the State of Pennsylvania, and the State Insurance Commissioner.

Effective Nov. 1, 1949, therefore, the definition of persons of low income became as follows: (1) Subscriber without dependents whose income does not exceed \$2,000 a year. (2) Subscriber with one dependent whose income, together with that of the dependent, does not exceed \$3,000 a year. (3) Subscriber with more than one dependent whose income, together with that of all income-earning dependents, does not exceed \$4,000 a year.

However, the raising of income limits was not the only expansion of benefits which was inaugurated by our Pennsylvania Blue Shield Plan during the past year. Following months of study, we announced in February the most extensive increase in benefits ever made—both for participating doctors and subscribers—at no increase in subscription rates.

Greatest Expansion of Benefits Announced

All of you are familiar with the new and greater benefits which became effective April 1, 1950: a new fee schedule providing payments up to \$200 (instead of the previous top limit of \$150) for a number of major surgical operations and an increase in payments for many other surgical operations; an increase from 21 to 70 days for payment of in-hospital medical care for subscribers to the Medical-Surgical Agreement; payment of \$10, instead of \$5, for the first day of such medical care; payment for one in-hospital bedside consultation per admission, and payment for home and office calls provided to the employed applicant subscriber only.

Certain limitations were attached to some of these new benefits, of course, but they are fully described in the new fee schedule which was distributed to all participating doctors.

Two precedent-shattering events occurred in connection with the announcement of these new benefits—by special permission of the State Insurance Commissioner, mass communications media were used to announce to subscribers and the general public that Blue Shield had increased its benefits, instead of mailing special notices to each subscriber, and the Commissioner himself recorded a message that went on the air over 50 radio stations to tell the public of the new benefits he had approved.

Praise from State Insurance Commissioner

But the Insurance Commissioner did more than just announce the new benefits—he also highly praised MSAP for its Blue Shield service. Said the Commissioner:

"The Pennsylvania Blue Shield Plan has grown tremendously in the past few years. As a result of this

growth, Blue Shield is providing all these additional benefits to subscribers without any increase in rates. When you consider that the extended plan will cost approximately one and one-quarter million dollars during 1950, you realize how admirable and truly American the Blue Shield Plan is. Here, my friends, is a demonstration of the American system of free enterprise at work—the system that offers us the most at the least possible cost."

This publicity, plus the news stories sent to newspapers by the Commissioner's office and by MSAP and the advertising carried in more than 100 papers, reached into every corner of the State with the good news that Blue Shield is the best possible voluntary, prepaid medical care plan.

No accurate estimate could be made of the effect upon enrollment of this announcement of new and expanded benefits. We do know that enrollment has continued to go up, some entire groups changed their coverage from the Surgical Agreement to the Medical-Surgical Agreement in order to obtain all of the new benefits, and subscribers have written to express appreciation for the fine service of Blue Shield.

All that has been presented in this annual report so far might easily produce the conclusion that the Medical Service Association of Pennsylvania has reached the pinnacle of success in providing Blue Shield medical care protection throughout the State. The statistics prove our healthy condition as the result of growth during the past twelve months. The adding of new benefits twice during the year without increasing subscription rates proves that we are attempting to provide a real service plan to subscribers. The continued growth in the number of participating doctors and their acceptance of all phases of policies and operations proves the solid position of Blue Shield in the Pennsylvania medical profession.

Goal for the Future

But, those to whom you have entrusted the stewardship of this community service are not satisfied, and will not be so until:

1. The number of subscribers reaches a far larger proportion of the population of the State.
2. Every practicing physician is not only a participating doctor in MSAP but also an enthusiastic supporter of and "salesman" for the Blue Shield Plan.
3. We provide the largest possible amount of service in helping to pay the doctor bills of our subscribers.

It is not selfishness on the part of MSAP which prompts these goals, but a realization that until they are achieved the Blue Shield Plan cannot be considered as the answer to the still burning question of voluntary or compulsory medical care insurance. We believe that what we have accomplished this past year has played a part in the success the medical profession and all other liberty-loving Americans have attained in battling the proponents of compulsory health insurance. But now is not the time to rest on our laurels.

To attain the number of subscribers in the Pennsylvania Blue Shield Plan which President Henderson of the AMA envisions as necessary to solve permanently the problem of voluntary or compulsory plans means

that we must add nearly six times as many subscribers in the next three years as we have obtained in the entire ten years of our history.

This goal can be achieved! But it will be won only through the wholehearted support of every member of the State Medical Society. That means not only membership in MSAP as a participating doctor but also the seizing of every opportunity by each "M.D." to tell everyone with whom he comes in contact—patients, colleagues, friends, neighbors, and community leaders—about the values of the voluntary way as the American way.

New Professional Relations Program

Not all of our problems of service and of efficient operation have been mastered. We are striving in the best way we know to solve them. As a practical means to enlist further the cooperation of participating doctors and to help them understand the operation of the Blue Shield Plan, MSAP's Board of Directors has authorized an expanded program of professional relations. A special committee of the board is working now on details of the program to cultivate further good relationships between the plan and its participating doctors. You will hear more about this new program soon.

We beseech your continued support and consideration as we face the future with its unknown circumstances which may have widespread effect upon all voluntary organizations.

We have faith that with your increasing help we can continue our forward progress and thus give further demonstration that "the doctors' own plan" is in the forefront of the struggle to keep America free.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA

STATEMENT OF CONDITION

as of July 31, 1950

Assets

Home office building	\$111,938.43
Bonds (amortized value)	2,002,505.29
Cash:	
in bank and in office	\$928,737.14
in transit	475,600.40
	1,404,337.54
Accrued interest receivable	6,020.79
Prepaid expenses	36,708.72
<i>Total admitted assets</i>	\$3,561,510.77

Liabilities

Reserve for expenses	\$3,067.27
Subscribers' deposits	623.40
Unearned subscription fees	388,751.76
Reserve for claims reported but unpaid ...	247,999.50
Reserve for unreported claims	470,917.00
Reserve for processing unreported claims	18,276.00
Reserve for deferred maternity care	458,259.50
Reserve for contingencies	1,973,616.34
<i>Total liabilities</i>	\$3,561,510.77

J. ARTHUR DAUGHERTY, *President*,
LESTER H. PERRY, *Secretary*,
GEORGE H. STEIN, *Treasurer*.

APPENDIX B

Army Procurement of Medical Officers

At a meeting between Gen. M. C. Stayer and Col. Harold W. Glattly (MC) on Oct. 16, 1950, Colonel Glattly outlined the procedure for induction of physicians subject to Selective Service as reserve officers.

1. On October 16 all physicians, category I (participants in the ASTP program with less than 90 days' service) and category II physicians (participants in the ASTP program with less than 21 months' service) will be required to register with their local draft boards. At the time of registration, each registrant will be given an information form DD390 to execute and return to the local draft board within five days. This form will provide the local draft board with a complete picture of the registrant's professional qualifications. Item 30 on this form allows the registrant to indicate whether he desires to apply for a reserve commission. It can be assumed that all physicians will indicate their desire to serve in the capacity of an officer instead of an enlisted man.

NOTE: We presume that those physicians trained in the V12 Navy program and those deferred during World War II for educational purposes will follow this same procedure.

2. The local draft boards, upon the advice of their medical advisers, will classify each registrant with respect to his availability for service, giving due consideration to his essentiality to the community or institution he serves.

3. Selective Service regulations require that all registrants in the classification of I-A (available for immediate entrance into the service) will be ordered to an Armed Forces Joint Physical Examining Station for pre-induction physical examination during the period of November 15 to December 15.

4. After the registrant has been physically examined, the report of his examination together with the form DD390 is forwarded directly to the Surgeon, Headquarters Second Army, Fort George Meade, Maryland. Determination is there made as to whether the registrant is acceptable to the Army both physically and professionally. If acceptable, a Certificate of Acceptability is made out upon the registrant and is forwarded to the State Director of Selective Service. At this same time, if the registrant has indicated that he desires a commission, he is notified to appear before a notary public and execute an oath of office.

5. Having executed an oath of office, the registrant is now a member of the Organized Reserve and is no longer subject to Selective Service. The local draft board will remove his name from the list upon presentation by the registrant of his oath of office for a reserve commission. The local draft board will then delete his name from the roster and will credit him against its quota.

6. Physicians who follow the routine outlined above will be eligible for the additional \$100 compensation.

7. Physicians who accept reserve commissions as

indicated above will be ordered into active service by Department of the Army orders.

8. Deferment is a function of the local draft board and its medical advisers. It is assumed that any registrant who is classified as I-A is, for the purpose of the Army, immediately available for call to active duty.

Special attention is invited to the following:

1. Any physician may volunteer to become a reserve officer and can do so by writing to or appearing in person before Col. H. A. Murphy, Chief of Pennsylvania Military District, 2620 Grays Ferry Avenue, Philadelphia.
 - A. Those who volunteer to become reserve officers will receive the consideration of the Committee on Procurement and Assignment of the State Society and will not be included in the Selective Service quotas.
 - B. Those who do not volunteer to become reserve officers will be subject to call through quotas submitted to their local Selective Service boards.
 - C. Quotas for reserve officers will be allocated to the various counties according to the number of physicians available.
 - D. As of this date, it is anticipated that approximately 25 medical officers per month until July 1, 1951, will be needed from the State of Pennsylvania.
 - E. Yesterday we received a quota for 12 medical reserve officers with the rank of colonel, lieutenant colonel, and major. These men will be used primarily as chiefs of services.

Record of Attendance of Members of the House of Delegates Representing Component County Societies at the 1950 Session in Philadelphia

(Figure indicates the number of elected delegates to which the county society is entitled plus its secretary or its president. The House of Delegates met on Monday, October 16, at 10 a.m.; Monday afternoon at 3 p.m.; and Wednesday at 10 a.m. The figure 1 following a name indicates the presence of the delegate at the first meeting; 2, at the second meeting; and 3, at the third meeting.)

Adams (2), Raymond M. Hale, 2, 3; Roy W. Gifford, 1, 2, 3.

Allegheny (17), William F. Brennan, 1, 2, 3; Paul G. Bovard, 1, 2, 3; William A. Bradshaw, 1, 2, 3; John W. Fredette, 1, 2, 3; Harold B. Gardner, 1, 2, 3; Wendell B. Gordon, 1, 2, 3; Elizabeth R. Child, 1, 2, 3; Francis X. Straessley, 1, 2; John S. Donaldson, 1, 2, 3; Carl F. Nill, 1, 2, 3; Norman C. Ochsenhirt, 1, 3; C. L. Palmer, 1, 2, 3; George C. Schein, 1, 3; James W. Speelman, 1, 2, 3; John E. Weigel, 1, 2, 3.

Armstrong (2), Cyrus B. Slcase, 1, 2, 3; Samuel V. King, 1, 2, 3.

Beaver (3), J. Willard Smith, 1, 2, 3; Fred B. Wilson, 1, 2, 3; Thomas W. McCreary, 1, 2, 3.

Bedford (2), no representation.

Berks (4), Matthew J. Boland, 1, 2, 3; William J. Goetz, 1, 2; Myer W. Dashe, 1, 2, 3; Archibald R. Judd, 1, 2, 3.

Blair (3), Elwood W. Stitzel, 1; Augustus S. Kech, 1, 2, 3; Ralston O. Getteny, 1, 2, 3.

Bradford (2), Stanley D. Conklin, 1, 2, 3.

Bucks (2), John F. McFadden, 1, 3.

Butler (2), J. Van S. Donaldson, 1, 2, 3; Charles B. Turnblacer, 1, 2, 3.

Cambria (3), Joseph W. Raymond, 1, 2, 3; John W. Barr, 1, 2, 3; Arthur Miltenberger, 1, 2, 3.

Carbon (2), B. Frank Rosenberry, 1, 2, 3.

Centre (2), Joseph A. Parrish, 1, 2, 3.

Chester (3), Michael Margolies, 1, 2, 3; Horace F. Darlington, 1, 2, 3.

Clarion (2), no representation.

Clearfield (2), Ward O. Wilson, 1, 2, 3.

Clinton (2), David W. Thomas, 1, 2, 3; Raymond A. Werts, 2, 3.

Columbia (2), Charles S. Yost, 2, 3.

Crawford (2), no representation.

Cumberland (2), E. Blaine Hays, 1, 2, 3.

Dauphin (4), Hamblen C. Eaton, 1, 2, 3; George L. Lavery, 1, 2, 3; Carl E. Ervin, 1, 2, 3; Constantine P. Faller, 1, 2, 3.

Delaware (4), E. Arthur Whitney, 1, 3; Joseph F. Dunn, 1, 2.

Elk (2), no representation.

Erie (3), Russell B. Roth, 1, 2, 3; Elmer G. Shelley, 1, 2, 3; George H. Ledger, 2, 3.

Fayette (3) Ralph L. Cox, 1, 2, 3; Edwin S. Peters, 3.

Franklin (2), Frank J. Corbett, 1, 2, 3.

Greene (2), Bruce R. Austin, 1, 2, 3.

Huntingdon (2), Francis S. Mainzer, 1, 2, 3; John M. Keichline, 1, 2, 3.

Indiana (2), Daniel H. Bce, 1, 2, 3.

Jefferson (2), S. Meigs Beyer, 1, 2, 3.

Juniata (2), Francis A. Stiles, 1.

Lackawanna (4), Philip E. Sirgany, 3; William J. Corcoran, 1, 2; William A. Coggins, 1, 2, 3; Joseph J. O'Brien, 1, 2, 3.

Lancaster (4), Henry Walter, Jr., 1, 2, 3; Roy Deck, 1, 2, 3; Joseph Appleyard, 1, 2, 3.

Lawrence (2), Wilbur E. Flannery, 1, 2, 3; Mary Baker Davis, 1, 2, 3.

Lebanon (2), no representation.

Lehigh (4), Pauline K. Wenner, 1, 2, 3; Robert L. Schaeffer, 1, 2, 3; Morgan D. Person, 1, 2, 3; Willard C. Masonheimer, 1, 2, 3.

Luzerne (5), Joseph W. Ehrhart, 1, 2, 3; Louis W. Jones, 1, 2, 3; Charles L. Shafer, 1, 2, 3; Herman A. Fischer, 1, 2, 3; Rufus M. Bierly, 3.

Lycoming (3), Charles A. Lehman, 1, 2, 3; Wilfred W. Wilcox, 1, 2, 3; Hartford E. Grugan, 1, 2, 3.

McKean (2), Persis S. Robbins, 1, 2, 3; Ralph E. Hockenberry, 1, 2, 3.

Mercer (2), Joseph J. Bellas, 1, 2, 3.
Mifflin (2), Joseph S. Brown, 1, 2, 3; Samuel L. Woodhouse, 1, 2, 3.
Monroe (2), Charles S. Flagler, 3.
Montgomery (5), Alice E. Sheppard, 1, 2, 3; Edgar S. Buyers, 1, 2, 3; M. Louise Gloeckner, 1, 2, 3; Elwood T. Quinn, 1, 3; Walter J. Stein, 1, 2, 3.
Montour (2), Henry F. Hunt, 1, 2, 3.
Northampton (3), James B. Butchart, 2, 3; Dudley P. Walker, 1, 2, 3; James E. Brackbill, 1, 2, 3.
Northumberland (2), Mark K. Gass, 1, 2, 3; T. Lamar Williams, 1, 2, 3.
Perry (2), Robert N. Reiner, 1, 2, 3.
Philadelphia (33), Malcolm W. Miller, 1, 2; William Bates, 1, 2, 3; John B. Montgomery, 1, 3; John V. Blady, 1, 3; Dorothy C. Blechschmidt, 1, 2, 3; Nathan Blumberg, 1, 3; W. Edward Chamberlain, 1; Louis H. Clerf, 1, 2, 3; Walter S. Cornell, 1, 2, 3; John T. Farrell, Jr., 1, 2, 3; Theodore R. Fetter, 1, 3; Leonard D. Frescoln, 1, 2, 3; Hayward R. Hamrick, 1, 3; Edmund L. Housel, 1, 3; Henry B. Kobler, 1, 3; Simon S. Leopold, 1, 3; Pascal F. Lucchesi, 1, 2; Theodore Melnick, 1, 3; Roy W. Mohler, 1, 3; Guy M. Nelson, 1, 2, 3; Donald C. Smelzer, 1, 3; Henry L. Gowens, 1, 2, 3; Milton F. Percival, 1, 2, 3; I. S. Ravdin, 1; J. Parsons Schaeffer, 1, 2, 3; John J. Shober, 1, 3; Frederick C. Smith, 1, 3; Martin J. Sokoloff, 1, 3; J. Hart Toland, 1, 2, 3; Joseph J. Toland, Jr., 1, 2, 3; Adolph A. Walkling, 3.
Potter (2), no representation.
Schuylkill (3), George A. Merkel, 2, 3; J. Stratton Carpenter, 1, 2, 3.
Somerset (2), Charles I. Shaffer, 1, 2, 3.
Susquehanna (2), Park M. Horton, 1, 3; John C. Cavender, 1, 3.
Tioga (2), Eleanor Larson, 1, 3; Thomas Dimitroff, 1, 2, 3.
Venango (2), James E. Hadley, 1, 2, 3; Frank E. Butters, 1, 2, 3.
Warren (2), Arthur J. O'Connor, 1, 2, 3.
Washington (3), Guy H. McKinstry, 1, 2, 3; Milton F. Manning, 1, 2, 3.
Wayne-Pike (2), no representation.
Westmoreland (4), Willis H. Schimpf, 1, 2, 3; Jo C. Griffith, 1, 2, 3; Leslie S. Pierce, 1, 2, 3.
Wyoming (2), Charles J. H. Kraft, 3.
York (3), H. Malcolm Read, 1, 2; Josiah A. Hunt, 1, 2, 3; Charles L. Fackler, 1, 2, 3.

MEMBER REGISTRATION BY COUNTY

<i>At Philadelphia Membership</i>			<i>At Philadelphia Membership</i>		
Adams	9	30	Lackawanna	37	299
Allegheny	101	1694	Lancaster	37	240
Armstrong	4	48	Lawrence	6	90
Beaver	16	130	Lebanon	8	74
Bedford	1	13	Lehigh	53	230
Berks	54	279	Luzerne	46	401
Blair	17	126	Lycoming	27	151
Bradford	11	51	McKean	2	53
Bucks	16	96	Mercer	6	97
Butler	4	67	Mifflin	6	40
Cambria	15	172	Monroe	12	41
Carbon	5	37	Montgomery	78	362
Centre	7	37	Montour	13	42
Chester	35	125	Northampton	32	205
Clarion	1	26	Northumberland	13	78
Clearfield	7	47	Perry	2	12
Clinton	5	31	Philadelphia	1323	3298
Columbia	8	46	Potter	1	11
Crawford	3	63	Schuylkill	22	158
Cumberland	7	47	Somerset	9	32
Dauphin	46	263	Susquehanna	2	15
Delaware	91	311	Tioga	3	27
Elk	1	25	Venango	7	50
Erie	15	219	Warren	2	52
Fayette	11	117	Washington	7	139
Franklin	7	81	Wayne-Pike	4	27
Greene	3	28	Westmoreland	10	221
Huntingdon	5	28	Wyoming	2	14
Indiana	1	43	York	15	181
Jefferson	4	59			
Juniata	2	6			
				2,297	10,985

SUMMARY OF REGISTERED ATTENDANCE

Members	2297
Guest physicians	11
Visiting physicians	286
Residents	383
Interns	218
Graduate students (doctors of medicine) ..	301
Total physicians	3496
Medical students	447
Nurses	218
Exhibitors	568
Woman's Auxiliary	357
Other visitors (including secretaries and technicians in doctors' offices)	931
Grand total registered attendance	6017

SCIENTIFIC MEETINGS

Monday, Oct. 16, 1950

GENERAL SESSION

The scientific program of the one hundredth annual session of The Medical Society of the State of Pennsylvania was called to order by Ralph L. Shanno, Forty Fort, chairman of the Committee on Scientific Work, at ten o'clock on Monday morning, October 16, in the ballroom of Convention Hall, Philadelphia.

A symposium on hepatic cirrhosis was presented at the first session. John H. Willard, Philadelphia, and Ralph L. Shanno, Forty Fort, presided. The first paper, "The Pathogenesis of Hepatic Cirrhosis," was read by Balduin E. Lucké, Philadelphia. "The Internist's View of the Treatment of Liver Disease" was the title of the paper presented by Charles S. Davidson, guest speaker from Boston, Mass. Robert R. Linton, Boston, Mass., another guest, gave the final paper of this symposium entitled "The Surgical Management of Hepatic Cirrhosis." Following a question and answer period, the symposium was concluded at twelve o'clock.

At 1:20 p.m. the meeting reconvened to hear a symposium on antibiotics and chemotherapeutic agents. Dr. Shanno acted as moderator. The first paper, "The Clinical Use of Neomycin—a Preliminary Report," was presented by John R. Wolgamot and Garfield G. Duncan, Philadelphia, and was read by Dr. Wolgamot. "Aureomycin, Chloramphenicol, and Terramycin" was the title of the paper given by Harrison F. Flippin, Philadelphia. Matthew S. Ersner, Philadelphia, next presented his paper on "The Role of Antibiotics in the Modern Treatment of Otorhinolaryngologic Conditions." This was followed by the presentation of Harold R. Vogel, Pittsburgh, entitled "The Present Role of Antibiotics in the Modern Treatment of Syphilis." The moderator then introduced the guest speaker, William A. Altemeier, Cincinnati, Ohio, who read his paper on "The Present Status of Antibiotic and Chemotherapeutic Agents in Surgery."

Following a twenty-minute intermission to view the exhibits, the group convened for the symposium on peripheral vascular diseases. Hugh Montgomery, Phila-

delphia, presented the first paper, "The Vasodilatation Test in Diagnosis of Peripheral Arterial Disease." The second presentation of this symposium was by a guest, Irving S. Wright, New York City, whose subject was "The Use and Abuse of Anticoagulant Drugs." Julian Johnson, Philadelphia, assumed the chair at this time and introduced Stuart N. Rowe, Pittsburgh, who delivered his paper on "Autonomic Surgery in Peripheral Vascular Disease." The final paper for the day was read by Robert R. Linton, guest speaker from Boston, Mass. It was entitled "The Surgical Treatment of the Postphlebotic Syndrome. The meeting adjourned at five o'clock.

Tuesday, Oct. 17, 1950

GENERAL SESSION

Tuesday's opening session was devoted to a symposium on pulmonary tuberculosis with Ralph L. Shanno presiding. The meeting was held in the ballroom of Convention Hall, Philadelphia, at nine o'clock.

The first speaker on the program was C. Howard Marcy, Pittsburgh, who spoke on "Responsibility of the General Practitioner in the Public Health Aspects of Tuberculosis." Next, a "Résumé of Early Diagnosis of Tuberculosis" was given by Edward A. Favis, White Haven, which was followed by the presentation of John S. Packard, Allenwood, on "Medical Treatment of Pulmonary Tuberculosis." Julian Johnson, chairman of the Section on Surgery, introduced the guest speaker for this session, Richard H. Overholt, Boston, Mass. His paper was entitled "The Benefits of Surgery in Pulmonary Tuberculosis." The meeting adjourned at 10:20 a.m.

SECTION ON MEDICINE

The Section on Medicine convened at 10:40 a.m. in the ballroom, Convention Hall, Philadelphia, with John H. Willard, Philadelphia, presiding.

The session opened with a paper by Eugene P. Pendergrass, Philadelphia, entitled "Some Considerations Concerning the Roentgen Diagnosis of Certain Lesions of the Chest." Then "Clinical Aspects of Primary Carcinoma of the Lung," a paper by John B. Flick and L. Donald Prutzman, Philadelphia, was read by Dr. Flick. Thomas M. McMillan, Philadelphia, next read a paper entitled "Pathologic Aspects of Primary Carcinoma of the Lung" which he had prepared in collaboration with A. Reynolds Crane, Philadelphia. William G. Leaman, Jr., Philadelphia, read his paper on "The Heart in Infection." As the final presentation of this session, the members heard Russell L. Cecil, guest speaker from New York City, give his paper on "The Treatment of Rheumatoid Arthritis." At twelve o'clock the session adjourned.

The moderator called the afternoon session to order at 1:20 p.m. and introduced Charles A. Laubach, Jr., Danville, who read his paper on "Organic Heart Disease and Pregnancy." A paper entitled "Etiology of Rheumatic Fever—A Critical Review" by Grace S. Gregg and Frank J. Gregg, Pittsburgh, was read by Frank J. Gregg. J. Franklin Robinson, Wilkes-Barre, read the next paper on "The Child as a Patient," and Edward Weiss, Philadelphia, followed this with his paper on "Emotional Factors in Cardiovascular Dis-

ease." The guest speaker for this session, George A. Wolf, Jr., New York City, presented a paper on "Headache." Adjournment was at three o'clock.

The final afternoon session was a clinicopathologic conference which convened at 3:20 p.m. R. Philip Custer, Philadelphia, was the pathologist, and Lucien A. Gregg, Pittsburgh, and Thomas M. Durant, Philadelphia, were the internists. The session was adjourned at 4:40 p.m.

SECTION ON SURGERY

The first session of the Section on Surgery was called to order by Julian Johnson, Philadelphia, at 10:40 a.m. in the Lobby Room of Convention Hall, Philadelphia.

The symposium on surgery of the hand was opened by L. Kraefer Ferguson, Philadelphia, who read his paper on "Management of Infections of the Hand." The second paper, "Present Concepts of the Early Treatment of Burns of the Hand," was given by Preston C. Iverson, Philadelphia, and was followed by William L. White, Pittsburgh, who presented a paper on "Reconstructive Surgery of the Hand." Sumner L. Koch, Chicago, Ill., spoke to the group concerning "Immediate Treatment of Hand Injuries." The morning session adjourned at 12:10 p.m.

The first part of the afternoon program was devoted to a symposium on acute conditions within the abdomen. The meeting convened at 1:20 p.m. with Philip J. Hodes, Philadelphia, reading his paper entitled "Roentgen Aids in the Diagnosis of Acute Conditions Within the Abdomen." "Acute Pancreatitis" was the subject of the paper presented by Norman M. Wall, Pottsville. This was followed by Harold G. Kuchner's paper on "Management of Acute Intestinal Obstruction," which was read by John R. Miller, Pittsburgh. The next paper, "Acute Appendicitis and Its Complications," was given by Jonathan E. Rhoads, Philadelphia. The guest speaker, Francis D. Moore, Boston, Mass., described "The Effect of Definitive Surgery on the Natural Course of Duodenal Ulcer Disease." An intermission was taken at three o'clock.

At 3:20 p.m. Stuart N. Rowe, Pittsburgh, started the concluding section of the afternoon program by presenting Francis F. Foldes, Pittsburgh, who read his paper on "The Physiologic Basis for the Choice of Anesthetic Agents and Methods." The next talk, "Recent Trends in the Treatment of Goiter," was given by Harold L. Foss, Danville, and Paul O. Klingensmith, Philadelphia, presented his paper on "The Management of Functional Uterine Bleeding." The paper entitled "Multiple Primary Malignancy," prepared by Clayton T. Beecham and Alfred S. Frautz, Philadelphia, was read by Dr. Beecham. The last speaker of the afternoon was a guest, Stuart W. Harrington, Rochester, Minn., who spoke on "The Diagnosis and Treatment of Intrathoracic Tumors." At five o'clock the meeting adjourned.

Wednesday, Oct. 18, 1950

GENERAL SESSION

A symposium on phases in the management of malignancy convened at nine o'clock in the ballroom of Convention Hall with Dr. Shanno presiding. The first speaker was Stanley P. Reimann, Philadelphia, who

read his paper on "The Modern Attack on Malignant Disease." Ralph Jones, Jr., Philadelphia, spoke next concerning "Metabolyte Antagonists" and this was followed by a paper on "Leukemia and Blood Dyscrasias" read by Lowell A. Erf, Philadelphia. Jerome F. Grunagle, Pittsburgh, presented his paper on "Control of Intractable Pain," and the final paper of the symposium, "Radioactive Isotopes," was presented by Richard H. Chamberlain, Philadelphia. The symposium was concluded at 10:20 a.m.

SECTION ON MEDICINE

The Wednesday meeting of the Section on Medicine convened at 10:40 a.m. in the ballroom of Convention Hall. Dr. Willard acted as moderator.

Hobart A. Reimann, Philadelphia, presented the first paper entitled "The Management of Fever of Unknown Origin." A series of papers dealing with allergies followed this. The first, "Diagnosis and Treatment of Allergic Rhinitis," was read by Malcolm W. Miller, Philadelphia. George E. Farrar, Philadelphia, gave "A Review of the Therapeutic Application of Antihistaminics." Concluding this series Will C. Spain, guest speaker from New York City, spoke on "The Case for Histamine as the Basis of Allergic Reactions: Attempts at Its Neutralization." The session adjourned at twelve o'clock.

At 1:20 p.m. the meeting reconvened and Francis T. O'Donnell, Wilkes-Barre, read his paper on "Immunization Program in Pediatrics." "Recent Advances in Immunology" was the topic of the talk given by Paul B. Kreitz, Bethlehem. The next speaker, Edith E. Nicholls, Danville, told of "Observations on 320 Cases of Acute Anterior Poliomyelitis," and the discussion on poliomyelitis continued with a paper entitled "Physical Medicine in Poliomyelitis" which was read by Jessie Wright, Pittsburgh. The guest speaker, Francis F. Schwentker, Baltimore, Md., then presented his paper on "Diagnosis and Management of Rheumatic Fever." An intermission was taken at three o'clock.

The last session of the afternoon meeting was called to order at 3:20 p.m. by Wendell J. Stainsby, Danville. "Home Care for the Convalescent and the Elderly" was the subject of the paper read by Richard R. Hoffman, Lebanon. James M. Straug, Pittsburgh, then gave his paper dealing with the "Treatment of Obesity." The third speaker, Thomas W. McCreary, Rochester, presented "The Relationship Between the Pathologist and the General Practitioner." "Treatment of Pruritus Ani" was the title of the paper read by Robert F. Dickey, Danville. The next speaker, Harold A. Taggart, Philadelphia, read his paper on "Protein Metabolism in Relation to the Nutritional Aspects of Certain Medical Diseases," and a paper on "Aspects of the Nutritional Management of the Seriously Ill" was read by Albert M. Lupton, Philadelphia. The meeting adjourned at 4:50 p.m.

SECTION ON SURGERY

The Section on Surgery convened at 10:40 a.m. in the Lobby Room of Convention Hall.

The morning program was devoted to recent advances in surgery and W. Emory Burnett, Philadelphia, presided. Robert P. Glover, Philadelphia, presented the

first paper, "Experimental Attempts at the Relief of Aortic Stenosis," which was co-authored by Charles P. Bailey and Thomas J. E. O'Neill, Philadelphia. The next speaker, Michael Scott, Philadelphia, described "The Neurosurgical Treatment of Non-traumatic Intracerebral Hemorrhage Simulating the Common Stroke." The third presentation, "The Rehabilitation Rate in Bronchiectasis," was given by George P. Rosemond, Philadelphia; and another Philadelphian, James D. Hardy, read a paper on "Changing Concepts in the Supportive Therapy of the Surgical Patient." The group then listened to their guest, Frank H. Lahey, Boston, Mass., present his paper on "Malignancy of the Stomach and Total Gastrectomy." The meeting adjourned at 12:05 p.m.

The afternoon session convened at 1:20 p.m. with Dr. Johnson presiding. The first paper, "Neurologic Sequelae of Spinal Anesthesia," was read by Robert D. Dripps, Philadelphia. The next three papers were related to the subject of low back pain. "Diagnosis and Non-operative Treatment of Low Back Pain" was the subject discussed by John S. Donaldson, Pittsburgh. Floyd H. Bragdon, Pittsburgh, read his paper on "Herniation of the Lumbar Intervertebral Disk: A Ten-Year Follow-up Study," and the final paper of the series, entitled "The Role of Spinal Fusion in Low Back Pain," was presented by Roy I. Peck, Philadelphia. The guest speaker for the afternoon was Edward G. Waters, Jersey City, N. J. He spoke on "Modern Concepts of Endocrinologic Therapy in Pregnancy." Following this there was a twenty-minute intermission.

A clinicopathologic conference which convened at 3:20 p.m. concluded the program of the Section on Surgery for the day. Morton McCutcheon, Philadelphia, was the pathologist and discussion was by John H. Gibbon, Jr., surgeon from Philadelphia, and William L. Estes, Jr., a Bethlehem surgeon. Adjournment was at five o'clock.

Thursday, Oct. 19, 1950

GENERAL SESSION

Dr. Willard called the meeting to order at nine o'clock in the ballroom of Convention Hall.

The final session of the combined sections on medicine and surgery was devoted to a symposium on ulcerative lesions of the bowel. A paper entitled "Medical Aspects of Chronic Non-specific Ulcerative Colitis" was given by Henry L. Bockus, Philadelphia. The second speaker was a guest from New York City, Burrill B. Crohn, and his subject was "Medical Aspects of Regional Ileitis." The final topic of the symposium, "Surgical Aspects of Ulcerative Colitis and Regional Enteritis," was presented by Richard B. Cattell, guest speaker from Boston, Mass. At 10:25 a.m. the symposium was concluded.

SECTION ON MEDICINE

The Section on Medicine convened Thursday morning at 10:40 in the ballroom of Convention Hall. Dr. Willard acted as moderator.

William A. Steiger, Philadelphia, read his paper entitled "The Diagnosis and Treatment of Hypopotassemia." Meyer Naide, Philadelphia, presented the sec-

ond paper which was on "Management of Patients with Intermittent Claudication." The next paper, "Observations in Penicillin-Treated Cardiovascular Syphilis," prepared by Joseph Edeiken, Mortimer S. Falk, William T. Ford, and John H. Stokes, Philadelphia, was read by Dr. Edeiken. A paper entitled "Use of Radioactive Iodine in Angina Pectoris" by Charles C. Wolferth, Richard H. Chamberlain, and John Mead, Philadelphia, was read by Dr. Wolferth. The guest speaker for this session was Clayton B. Ethridge, Washington, D. C. His subject was "Diagnosis and Therapy in Various Forms of Coronary Heart Disease." The meeting adjourned at twelve o'clock.

SECTION ON SURGERY

The final meeting of the Section on Surgery was called to order by Dr. Johnson at 10:40 a.m. The session was held in the Lobby Room of Convention Hall.

"Medical Treatment of Cataract" was the subject of the paper by Arno E. Town and Abraham E. Rakoff, Philadelphia, and was read by Dr. Town. The second paper, prepared by Alex W. Ulin, Paul J. Grotzinger, Charles L. Sacks, and William L. Martin, Philadelphia, and read by Dr. Ulin, was entitled "Diagnostic and Therapeutic Problems of Acute Large Bowel Obstruction Due to Carcinoma of the Colon." Boland Hughes, Philadelphia, then presented his paper on "The Management of Hydronephrosis." The final speaker, a guest, was Richard B. Cattell, Boston, Mass., whose paper was entitled "The Surgical Treatment of Benign Lesions of the Pancreas." The session adjourned at twelve o'clock.

RELATIONSHIPS BETWEEN HOSPITALS AND DOCTORS OF MEDICINE

EDITOR'S NOTE: The appended report may at first glance appear formidable to the casual reader. However, to the personnel of the Committee on Hospital Relations of any county or state medical society confronted with formal charges alleging unfair application of the principles of relationships between hospitals and doctors of medicine against a local hospital, the entire report (more than 3000 words) may prove indispensable to medical society Committees on Hospital Relations. May we suggest that the personnel of such committees clip and file this report.

Report of the Committee on Hospitals and the Practice of Medicine

(As amended and approved by the House of Delegates of the American Medical Association, June, 1950)

In June, 1949, the House of Delegates approved a report, as revised by the reference committee, submitted by the Committee on Hospitals and the Practice of Medicine. Subsequent to this meeting and after receiving a legal opinion from the association's general counsel, the Board of Trustees referred the entire report back to the House with specific recommendations concerning portions of the report.

In December, 1949, the House of Delegates approved the following resolution in regard to this report:

"... that in the interests of maintaining high professional standards and protecting the public health, the House of Delegates reaffirms the philosophy underlying and the principles enunciated in the Hess Committee report, and that in view of the possible legal technicalities, the activation of the Hess Committee report be deferred until after the next meeting of the House of Delegates and that between this and the next meeting of the House of Delegates the original report be re-referred to the original committee or reasonable facsimile thereof and that the committee be instructed to consider ways and means of activating the original report in accordance with the principles expressed therein and in accordance with legal considerations which must be present."

In view of this resolution of the House of Delegates, the Correlating Committee on Extension of Hospitals and Other Facilities of the Council on Medical Service consisting of the original members of the Committee on Hospitals and the Practice of Medicine plus two additional members appointed by the council has undertaken to restudy the problem and rewrite the report in such manner as to meet the directives of the House of Delegates.

In addition to studying the original report, the committee requested expressions of opinion on the part of the various specialty groups and of the various hospital associations and also granted them permission to have representatives appear before the committee if they so desired.

The committee wishes to report again that so far as it can determine, on the basis of a study made by the Bureau of Legal Medicine and Legislation of the American Medical Association, as a matter of law the corporate practice of medicine is illegal in most states. In almost all instances the classic example given by the courts of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a professional man and then sells his services to the public on a fee basis for the profit of the corporation. Such exceptions as there are refer to statutory legislation in several states permitting certain modifications of this general law. It must also be remembered that fee splitting with a corporation is just as unethical as fee splitting with another physician.

In addition to being guided by the laws of the various states, physicians in their relationships with hospitals must be guided by the Principles of Medical Ethics of the American Medical Association. Those sections of the Principles which have a distinct bearing on these relationships are as follows:

Chapter I. Sec. 3. "Groups and Clinics—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession."

Chapter III. Article VI. Sec. 2. "Conditions of Medical Practice—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care."

Chapter III. Article VI. Sec. 3. "Contract Practice—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

"Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered."

Chapter III. Article VI. Sec. 6. "Purveyal of Medical Service—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

In conclusion, the Principles of Medical Ethics states: "These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. . . ."

On page 31 of the Constitution and By-laws as printed in the Handbook under the Duties of the Judicial Council, is found the following:

"The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the laws of the Association.

"The Council at its discretion may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary.

"The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the president, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused."

If and when a physician is found to be unethical by the proper authorities as established through channels specified in the Constitution and By-laws, and he is still retained on the staff of any hospital approved for resident or intern training by the Council on Medical Education and Hospitals, it shall be the duty of the Judicial Council to request the Council on Medical Education and Hospitals to show cause as to why that Council should not remove such hospital from the approved list under the assumption that the hospital is just as unfit for the training of young physicians for unethical reasons as it is unfit because it may not or does not have proper filing systems for its laboratory or clinical records.

Another matter which the committee believes pertinent as regards the problem of physician-hospital relationships is the set of principles prepared by the Council on Professional Practice of the American Hospital Association (Robin C. Buerki, M.D., chairman) and approved in 1946 by the Board of Trustees of the American Hospital Association, the American College of Surgeons, representatives of the various specialty groups (anesthesiology, radiology, and pathology), and the Council on Medical Education and Hospitals of the American Medical Association.

These Principles of Relationship Between Hospitals, Radiologists, Anesthetists, and Pathologists emphasize that the primary obligation of both physicians and hospitals is to serve the best interest of the patients. This the committee believes leads to a fundamental principle that the decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. These principles also recognized the basic fact that all of the various questions involved in the relationship between physicians

and hospitals, both legal and ethical, must be considered in the first instance at the local level because of the various differences which of necessity exist in the many sections of the country. Again, the committee believes that this gives us another fundamental principle, that, consonant with established principles of medical ethics, local conditions must decide the various arrangements and conditions of practice in reference to both hospital facilities and medical personnel and their relationships.

One of the factors that have aggravated physician-hospital relationships is the inclusion of medical services in the contracts of voluntary hospital service plans. The medical profession is fostering voluntary health insurance, and we believe that nothing should be done to disturb this very important and essential program. However, the American Medical Association has reaffirmed many times through its then Bureau of Medical Economics, its Judicial Council, and the House of Delegates the principle that hospital service plans should exclude all medical services, and the contract provisions of such plans should be limited exclusively to hospital services. At the same time, so that there would be no misunderstanding as to which services should or should not be included, the House of Delegates has stated that "... if hospital service is limited to include only hospital room accommodations, such as bed, board, operating room, medicines, surgical dressings, and general nursing care, the distinction between hospital service and medical service will be clear."* Furthermore, past actions of the House of Delegates give the committee every reason to reiterate that radiology, anesthesiology, pathology, and psychiatry constitute the practice of medicine.

In order to initiate a method for remedying this situation, it is recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services. Your committee believes that the professional and hospital authorities and the voluntary prepayment plans will cooperate in furthering these recommendations.

The committee believes that since the physician and hospital are interdependent, it is incumbent on both to be interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also toward hospital management. The recommendations of the staff concerning medical matters are usually accepted by the management of the hospital through its board of managers or trustees. It must also be remembered that to be approved for residencies in specialties by the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, among them adequate pathologic and radiologic coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends

who may or may not use the institution for professional work. Unfortunately, in many instances, the financial problems of the lay hospital management have been no affair of the staff or of its professional executive committee. This is wrong and probably the cause of most of the differences of opinion between physicians and hospital management. The financial problems of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these problems if the hospital is to work efficiently and remain the workshop of the physician, and without proper facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff.

Every professional man on the appointed staff should have a voice in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist and psychiatrist, as well as the other professional staff members, should have equal standing as active members of the staff with all the rights and privileges pertaining to other members of the staff of equal standing. The chiefs of these departments should be nominated and appointed in the same manner as are the chiefs of other major departments in the same hospital.

The revised Principles of Medical Ethics has been written with all of these various factors in mind and is broad enough to cover all possible ethical physician-hospital relationships. The Constitution and By-Laws of the American Medical Association distinctly covers methods of procedure for all persons who have a complaint so that they may approach the Judicial Council. The functions of that council are specifically delineated.

For the purpose of activating this report, the committee has the following suggestions:

In the event of a controversy between physician and physician, or physician and hospital management, on these problems, it is recommended that, since local conditions must be taken into consideration, these problems be resolved insofar as possible at the local level.

The committee believes that there can be no exploitation of the doctor or of the hospital if everyone concerned in management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public. In any given controversy, every effort should first be made to settle the matter at the staff-management level. In case of failure to settle the controversy at this level, assistance of the county medical society should be requested. If, then, it cannot be resolved, it should be submitted to a committee of the state medical association for advice and recommendation. If problems cannot be solved at the staff-management level, through the county medical society, or through the state medical association, the Constitution and By-Laws of the American Medical Association provides that "... the (Judicial) Council may, at its discretion, investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and make such recommendations to the House of Delegates or the constituent association as it deems necessary."

To implement the settlement of such controversies, it is recommended that each component medical society and each constituent state and territorial medical association appoint a Committee on Hospital and Professional Relations. This committee should be available to receive complaints from any physician, hospital, medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals. On receipt of such complaint by such a committee the mat-

* Proceedings of the San Francisco Session of the House of Delegates, 1938, p. 31.

ter should be investigated and acted on in such manner as will best effect adjustment of the complaint.

Your committee has already communicated with every state in the Union requesting that a Committee on Hospital and Professional Relations be created at the state level to assist similar committees at the county society level in solving these disagreements wherever they arise. Many states have already established these committees, and they are functioning.

Another approach that should not be neglected in activating this report is that of the local and state hospital associations. Most of the states and many communities have hospital associations providing direct representation for the hospitals within their areas. It seems reasonable to assume that state medical associations and component county medical societies could well effect liaison with these organizations in the settlement of problems involving physician relationships.

The following principles are additional guides to individual physicians, county medical societies, and state medical associations:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement, if any, between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

3. The practice of anesthesiology, pathology, physical medicine, and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine, or any other designated field of medicine.

Finally, in order that progress regarding the activation of the report may be followed, the committee suggests that the House of Delegates authorize this committee to keep in touch with the Committees on Hospital and Professional Relations appointed by the county medical societies and the state medical associations and report on such progress at the next annual meeting.

ADDENDUM: SUPPLEMENTARY REPORT OF THE COMMITTEE ON HOSPITALS AND THE PRACTICE OF MEDICINE

The committee believes that if the following pattern were followed the possibility of solving any controversy between physician and hospital would be greatly improved:

When a physician believes that he has a legitimate complaint against hospital management, he should first attempt to solve the difficulty at the staff level. And it is incumbent on the medical staff to assist in arriving at a fair and proper solution.

If no solution is reached at this level, the physician should appeal to the appropriate committee of his county medical society for advice and assistance. The county medical society committee should develop methods for contacting hospitals, management and boards, as well as local associations representing hospitals, in order that all sides of the controversy may be understood and personality difficulties minimized.

When a solution seems impossible through the good offices of the county medical society, mechanisms should be available for presentation of the matter to the state

medical association of which the physician is a member. Here again, for the purpose of receiving all available facts and opinion, the state medical association should develop liaison with the state hospital association.

To facilitate the consideration and mediation of physician-hospital controversies, specific authorization to handle such matters should be given to some committee of both county and state medical societies. In the larger county societies and the state associations this function could be best carried out through a special committee created for just this purpose. It should be the function of such committees to mediate differences in the light of the existing state laws, the Principles of Medical Ethics, and the best interests of the patients.

The services of the Correlating Committee on Extension of Hospitals and Other Facilities of the Council on Medical Service, working with a similar committee of the American Hospital Association, should be available to study and assist in solving physician-hospital problems which seem unsolvable at the local and state levels. For formal opinion or adjudication, however, the portfolio should be presented to the Judicial Council.

(The recommendation of the reference committee that the supplementary report be referred to the Judicial Council was approved by the House of Delegates.)

IS MEDICINE A TRUE PROFESSION?

John Schoff Millis, Ph.D., LL.D., president of Western Reserve University, speaking before the Medical Alumni Association of that university, directed some thought-provoking consideration on the question of what is a profession.

The true meaning of the word "profession" can be obtained only from the verb from which the word is formed, namely, "profess." What do you profess? That is, what do you believe? What is your faith? What do you hold to be the supreme truth?

We in America accept as demonstrated that man, unlike any other occupant in the known universe, has a mind, spirit, and free will. The possession of these three attributes, at least in potential form, so distinguishes man that he is entitled to special privileges—those we describe as life, liberty, and the pursuit of happiness. Because he can understand by intellectual mastery, because he can appreciate by spiritual insight, and because he can act rationally through the operation of his will, man is the unique part of the universe and must be provided with unique rights and responsibilities. This is, in my opinion, what you profess. This is your fundamental belief, this is your guiding faith which makes the practice of medicine a true profession.

If your profession is that the individual man counts, and never men in the mass, then the practice of medicine must be built around the individual patient and not around a collective society. The profession of medicine must be individualized, not collectivized.

If we believe as I think we do, we will reject all mass plans, all so-called socialized plans. . . . Though we must reject any plan which concerns men in the mass

we must be interested in and sympathetic to the needs of every man.

What do you profess?—*The Ohio State Medical Journal*.

THE PUNCHING BAG IN REHABILITATION

By J. L. RUDD, M.D., and REUBEN J. MARGOLIN, M.A.,
Boston, Mass.

A valuable piece of exercise equipment for a medical gymnasium—potentially useful, but seldom employed—is the punching bag. It is readily available; the overhead platform drum is easily constructed; and it is inexpensive.

In any exercise program, one of the first factors to be considered is avoidance of the monotony and boredom of the routine prescription. A second factor is the improvement of a specific pathologic condition as a result of the activity.

Carefully selected cases of shoulder disability have been treated by the use of the inflated pear-shaped leather bag, in addition to the usual physical, occupational, and corrective therapy. A number of diseases and injuries of the upper extremities, especially in the region of the shoulder and elbow, are amenable to this type of corrective therapy. Patients with subdeltoid or subacromial bursitis, as well as those with dislocation or fracture of the shoulder or elbow joint, can expect gains in strength and in range of motion in specific planes.

In certain conditions we were able to aid the patient in regaining an appreciable measure of coordination and rhythm. Few gymnasium exercises require a greater synergistic action of muscles than striking the bag. Rhythmic mental responses foster the element of awareness, aid in re-establishing the reflex arc, and combat what may be a very disabling psychologic block or "mental alienation."

All punching-bag exercises should progress from the very simple to the more complex. The patient should learn to strike the bag in a manner which will benefit his particular condition.

After the acute stage of bursitis has passed, when increased motion in abduction and forward flexion is sought, a low-hanging punching bag may be employed in addition to the usual physical therapy. Absorption in this activity minimizes the feeling of pain and allows greater joint mobility. This interest has been found more difficult to evoke in other routine exercises.

For recurrent dislocation, straight punching exercises can be used to build up muscle tone and to enlarge and strengthen the muscle mass around the shoulder girdle. In this way the head of the humerus can be given more muscle support to help keep it in the glenoid fossa in spite of a stretched and torn capsule.

For fractures about the elbow joint, a punching motion with pulley weights affords effective rehabilitation. However, active extension of the elbow against resistance, with reflex relaxation of the flexors, can be most effectively accomplished by straight punching of the bag. Again, the absorption in the "doing" and the "learning" of the skill lessens concentration on pain, thus allowing more activity earlier.

The shoulder-hand syndrome, the nature of which is

not completely understood, consists of pain in the shoulder or hand, or both. Shoulder motion is limited by pain; the affected hand becomes edematous and so uncomfortable that it is held stiffly. One of the best methods of treating such a causalgic state is believed to be vigorous therapeutic exercise, which should be continued for a long period, despite the attendant discomfort and pain. The punching bag can be beneficially employed in the few patients with the shoulder-hand syndrome who are able to concentrate sufficiently on this activity to lessen their attention on the pain caused by the motion of the upper extremity.—Abstracted by ALBERT A. MARTUCCI, M.D., from the *Journal of Bone and Joint Surgery*, July, 1950.

THE CHANGING ROLE OF PRIVATE PHILANTHROPY

President Chester I. Barnard's* review of the activities of the Rockefeller Foundation in 1949, in addition to enumerating grants that would once have been considered large, emphasizes significant trends in the present role of private philanthropy abroad and at home. "Profound political changes" forced the Foundation to abandon important projects in certain countries under the domination of Soviet Russia (Poland, Czechoslovakia, Hungary, and China), and private support of research and education no longer represents the main (or even an important) source of revenue in these fields. In the words of its president, the Foundation has been sharply awakened to "the discrepancy between the resources of privately endowed organizations . . . and the magnitude of funds needed today for large-scale research or educational enterprises." The money formerly allocated to projects in countries behind the Iron Curtain has had to be expended elsewhere, and the slack between the resources of private philanthropy and the budgetary needs of scientific, educational, and social institutions is being increasingly taken up by governmental grants.

Both trends probably represent what may be expected for some time to come: the expansion of Russia gives no indication of ending in the predictable future, and the lavish grants of the United States Government are likely to be sought by—and awarded to—more and more institutions. Thus, for better or worse, organizations like the Rockefeller Foundation are being forced to accept a minor part in a field in which they were once outstanding (the Foundation's appointments to fellowships for study abroad constituted hardly 2 per cent of the 15,070 awards offered in 1949, and those of government agencies 62.5 per cent). Nevertheless, the projects supported by the privately endowed institutions are of undiminished value. Until the fully developed and all-encompassing welfare state has taken firm hold, private philanthropy will continue to fill a vital need in the United States and in the world; *endowments from this source, administered without the waste and inefficiency that seem to be the inevitable accompaniment of bureaucracy, will continue to be welcomed by institutions fortunate enough to remain off the cultural dole.*—Editorial, *The New England Journal of Medicine*, July 20, 1950.

* BARNARD, C. I.: *The Rockefeller Foundation: A review for 1949*. 85 pp. New York: Rockefeller Foundation, 1950.



OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D.,

Secretary-Treasurer



Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

DR. MEILING URGES LOWER RATIO

Risking further displeasure on the part of Army and Navy regulars, Dr. Richard L. Meiling came out emphatically in favor of a 3.5 doctor ratio in an address Thursday before the Association of Military Surgeons in New York City. To adhere to the traditional formula of 6 or 6.5 medical officers for 1000 armed strength is not only to overstaff but to make for unnecessary deprivation of the civil population, said the medical services director of the Department of Defense. That his recommendation received no enthusiastic reception by the military medical career men, assembled for their annual convention, surprised no one, least of all Dr. Meiling.

The biweekly meeting of the Rusk advisory committee to Selective Service on Friday and Saturday was devoted chiefly to discussion of numerous quirks in the doctor-draft law. No major decisions were reached and no broad policies adopted. A new medical member of this group may be seated at its next meeting November 20-21. NOTE: Selective Service reports that 4122 physicians and 1952 dentists who registered October 16 have been placed in 1-A and 1-AO (conscientious objector) classifications.—Washington Report on the Medical Sciences, Nov. 13, 1950.

HONOR ROLL INFORMATION

As of Dec. 14, 1950, the 1951 dues of the State Society and AMA have been paid as follows: Allegheny County—234, 233; Bucks County—18, 18; Montgomery County—103, 103.

Watch this honor roll grow in succeeding issues of the JOURNAL.

POSTER CONTEST SUCCESSFUL

The 1950 Health Poster Contest sponsored by The Medical Society of the State of Pennsylvania was one of the most successful since this state-wide feature was inaugurated in 1938.

Thirty-one county medical societies conducted elimination contests and an estimated 10,000 posters were submitted by public and parochial school children from the first through the twelfth grades. Cash awards were given by each county society and the winning posters were entered in the state-wide contest held in connection with the annual session in Philadelphia. The Woman's Auxiliary to The Medical Society of the State of Pennsylvania has taken an active part in the project, assisting in those counties which held contests.

On October 8, four judges met in the Bellevue-Stratford Hotel with several invited guests and, following a luncheon, selected from the 350 county medical society winners the prize posters in the state contest. The judges included Mrs. Dorothy Waldo Phillips, of Lansdowne, author and lecturer on youth guidance; Mrs. Marjorie Heilman, of Lititz, painter-illustrator, a daughter-in-law of Dr. Marlin W. Heilman, of Tarentum; George T. Miller, Harrisburg, Chief of Art Education for the Pennsylvania Department of Public Instruction; and Dr. Samuel G. Shepherd, a Philadelphia physician, whose paintings have won awards from the American Physicians Art Association.

The winning posters in the state-wide contest were exhibited at the annual session in Convention Hall, Philadelphia, and during the month of November were on display in the Pennsylvania State Museum, adjoining the Capitol in Harrisburg. The following letter was received from the Pennsylvania Historical and Museum Commission:

DEAR MR. JANSEN:

I have your letter of December 1 and in reply I wish to say that we were very happy to have your display of health posters here in the Museum.

During the time they were here, over 20,000 visitors had the opportunity of seeing them, and of this number approximately 15,000 were children of school age.

I feel that an exhibit such as yours has an exceptional educational value and I hope you will see fit to repeat it next year.

With kind regards, I am

Sincerely yours,

CHARLES M. STEESE,
Museum Administrator.

The winning posters are being exhibited in Mercer and Berks counties under the auspices of the woman's auxiliaries for those counties and are available for display in schools and before parent-teacher association and woman's auxiliary meetings.

Mrs. John V. Foster, Jr., of Harrisburg, was chairman of the 1950 Health Poster Contest for the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, and Mrs. John R. Spanuth, of Reading, is chairman of the 1951 contest.

Mrs. Drury Hinton, past president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, wrote, following the 1950 contest, "It is my sincere wish that more county medical societies and auxiliaries consider the poster project a 'must' for the coming year. I believe it to be one of the finest public relations projects we have."

The 1951 Health Poster Contest is now under way.

1950 AMA DUES

To 643 members of The Medical Society of the State of Pennsylvania who have not paid 1950 AMA dues (letter mailed November 17):

As of this date only 643 of our state society's 10,450 members have failed to pay their 1950 AMA dues (\$25).

According to our office files, you are one of our state society members in good standing who has not paid 1950 AMA dues. You will remain in good standing in the AMA until Jan. 1, 1951. As of that date the 5 per cent from Pennsylvania who have not paid will be dropped by the AMA and not be reinstated until delinquent dues are paid.

You doubtless have previously thought of your

personal responsibility to maintain your individual standing, but have you realized that the number of delegates representing your state society in the national councils is mathematically based on the number of AMA members from Pennsylvania? Upon your payment of these dues, therefore, rests not only your continued full medical citizenship but the prevention of a reduction in the number of Pennsylvania delegates to the American Medical Association.

Won't you then thus do your current part in preventing further curtailment of our profession's liberty in practice?

Your check received at this office will be forwarded promptly to the AMA and receipt acknowledged.

WALTER F. DONALDSON, *Secretary-Treasurer*.
Nov. 20, 1950

ADMISSION TO MEDICAL SCHOOL

In recent years the difficulties that students encounter in gaining admission to medical school have been greatly magnified in the minds of many of the public and the medical profession alike. In public and private discussions of the subject the belief has not infrequently been expressed that the medical schools will admit only students who have made an "A" average in college or that only one out of every 10 or 15 of those who apply can be admitted.

The current report of the Council on Medical Education and Hospitals reveals that last year 73 per cent of the 74 medical schools in the United States that submitted data on this subject admitted some students who had made less than a "B minus" average in their college work. Actually 9 per cent of the freshmen in the 74 medical schools reporting fell in this category. Statistics were not obtained as to the number of other students who were admitted with less than an "A" average, but it may be presumed to be large. In considering an applicant for admission, a medical school must of necessity weigh heavily his past scholastic achievements. Most medical schools, however, would not consider selecting their students on the basis of marks alone, any more than patients would be willing to choose their physicians solely on such a basis. Medical schools properly recognize that outstanding qualities of character, personality, aptitude, and motivation can compensate for a relatively low academic standing.

With respect to the ratio of accepted students to applicants, official figures compiled by the Association of American Medical Colleges show that a total of 24,434 persons applied for admission to the 1949 freshman class in the medical schools of the United States. This class numbered 7042 students. Thus, approximately one out of every 3.5 applicants was successful in gaining admission.

The experience of every medical school demonstrates

that each year large numbers apply for admission whose only qualification is the wish to study medicine. If statistics could be obtained which would make it possible to eliminate from the total number of applicants the grossly unqualified and those reapplying after being rejected in previous years, it would probably be found that the difference between the number of students accepted in a given year and the number of qualified applicants who completed their undergraduate college work in that year would not be great. It is important that there be a better understanding generally of this fact. Otherwise many capable young men may be misguidedly discouraged from considering the study of medicine.—*J. A. M. A.*, Sept. 9, 1950.

SUCCESSFUL INDUSTRIAL HEALTH CONFERENCE

DR. WALTER F. DONALDSON, *Secretary*,
Medical Society of the State of Pennsylvania.

The Third Gulf Coast Regional Conference on Industrial Health was held in Houston, Texas, Oct. 12-14, 1950. As quarterback, the Public Health Committee of the Houston Chamber of Commerce received excellent team support from the state and local health departments, Baylor and Texas University Medical Departments, the safety engineers, Manufacturers Association, industrial nurses, and the Industrial Health Section of the local county medical society. The attendance of around 400 included approximately 15 per cent physicians, 20 per cent nurses, 25 per cent industrial hygienists, and 40 per cent representatives of management. Local organized labor had been invited to act as co-sponsors and to participate in the conference, but declined. Mr. Harry Read of the CIO was present and participated in two of the conference panels. . . .

At the luncheon on October 12, Dr. Robert L. Sutherland, Director, Hogg Foundation for Mental Hygiene, University of Texas, indicated the importance of bringing the working man, the ultimate consumer, into the planning for services which are designed for his benefit. He stated that most of the antagonisms and negative emotional responses that are encountered throughout society are due to lack of information, misinformation, and misinterpretation of situations. . . .

On October 13 the morning session was divided into two meetings running concurrently; one group considered the placement of the physically handicapped in industry, while the other group participated in a symposium on industrial wastes and stream pollution. . . .

The midyear board meeting of the American Association of Industrial Nurses met concurrently with the conference. The program on Saturday, October 14, was for the industrial nurses. Dr. R. B. O'Connor, Division Medical Director, Loss Prevention Department, Liberty Mutual Insurance Company, gave an unusually interesting discussion of Liberty Mutual's recent efforts in developing small plant industrial health programs. He listed the following prerequisites that are necessary for a successful health unit:

1. Medical department interest in industrial health, going beyond medical care in a "preventive minded"

way to forestall accidents and diseases.

2. Medical service must come into the plant.

3. Management interest and support.

4. Primary aim to benefit employees.

The conference has had a healthy growth during these past three years indicating an increasing consciousness of the need for expanding the industrial health educational and service facilities to meet the problems created by the rapidly increasing industrialization of this area. The regional appeal of the meeting was demonstrated by the attendance of representatives from all sections of Texas as well as from Oklahoma, Arkansas, and Louisiana.

J. F. McCahan, M.D., *Assistant Secretary*,
Council on Industrial Health,
American Medical Association.

Nov. 30, 1950

CHANGES IN MEMBERSHIP

New (43) and Reinstated (20) Members

ALLEGHENY COUNTY: (Reinstated) William M. Mitro and Henry M. Snitzer, Pittsburgh.

BLAIR COUNTY: (R) Daniel R. Mock, Harold E. Reed, and Daniel M. Repogle, Altoona.

BUCKS COUNTY: (R) Esther M. Buchanan, Salt Lake City, Utah.

CAMBRIA COUNTY: Lester O. Gregg, Jr., Johnstown. (R) Francis P. Dostal, Conemaugh, and John J. Silensky, Madera.

DAUPHIN COUNTY: James W. Green, Highspire.

ERIE COUNTY: Robert McKay Boughton, Erie.

FAYETTE COUNTY: (R) Robert A. Rupp, Uniontown.

LANCASTER COUNTY: Kenneth M. Carroll and Edward L. Lancaster, Jr., Lancaster. (R) Paul R. Evans, Elizabethtown.

LEHIGH COUNTY: (R) Bruce R. Marger, Allentown.

MERCER COUNTY: (R) James F. Elder, Sharon.

MONROE COUNTY: Morton H. Spinner, East Stroudsburg.

MONTGOMERY COUNTY: Juddson E. Shepard, Norristown (affiliate member).

PHILADELPHIA COUNTY: Lewis A. Barness, Warrington; William C. Adamson, Herman F. Boerner, Ernest M. Brown, Jr., Jay M. Chaus, Donald R. Cooper, Henry M. Drinker, Nathan Epstein, Roger E. Fox, Edward Gosfield, Jr., Charles F. Grabske, Jr., William M. Hart, Benton D. King, John W. Lachman, Leonard J. Levick, Elizabeth M. Mertens, John J. Mozzanotte, Allen C. Miller, Evelyn McC. Pebley, Robert F. Plotkin, Theodore P. Reed, James L. Roth, Walter B. Shelley, Leroy D. Soper, William A. Steiger, III, Stanley A. Tauber, Mark W. Wolcott, and John R. Wolgamot, Philadelphia. (R) Jacob M. Benson, Frank W. Burge, Harry W. Cohen, James S. C. Harris, Edmund V. McKinley, Morris M. Maser, David J. Phillips, Joseph A. Smith, Louis N. Taine, James A. Thomas, and William

C. Wermuth, Philadelphia; Harold Lefkoe, Jenkintown; Robert S. Mutch, Wilmington, Del.; Abdullah K. Sallom, Upper Darby; H. Edward Yaskin, Camden, N. J.

WASHINGTON COUNTY: Benjamin Super, Washington.

WESTMORELAND COUNTY: George M. Kiebler, Saltsburg.

Resignations (2), Transfers (20), Deaths (10)

ADAMS: *Transfer*—Philip D. Zulick, Littlestown, from York County Society.

ALLEGHENY: *Transfers*—Francis X. Bauer, Tarentum, from Philadelphia County Society; Robert C. Burt, Pittsburgh, from Crawford County Society.

ARMSTRONG: *Transfer*—Thomas W. Enfield, Rural Valley, from Indiana County Society.

BEAVER: *Death*—Margaret I. Cornelius, Beaver (Univ. of Pgh. '09), October 7, aged 72.

BUCKS: *Death*—John B. Carrell, Hatboro (Jeff. Med. Coll. '76), September 20, aged 99.

CAMBRIA: *Death*—Thomas J. Cush, Johnstown (Jeff. Med. Coll. '24), September 30, aged 49.

ERIE: *Transfers*—John A. Fust, Hamot Hospital, Erie, from Philadelphia County Society; Frederick R. Gabriel, Erie, from McKean County Society; Stephen R. Keister, Erie, from Allegheny County Society; Richard C. Lyons, Erie, from McKean County Society.

FRANKLIN: *Transfers*—Alfred S. Frantz, Chambersburg, from Philadelphia County Society; Forrest F. Smith, Chambersburg, from Indiana County Society.

LANCASTER: *Transfer*—Paul R. Davidson, Lancaster, from Franklin County Society. *Death*—Edward K. Smith, Lancaster (Univ. of Pa. '18), September 11, aged 55.

LEHIGH: *Transfers*—Raymond Shettel, Allentown, from York County Society; Richard K. White, Allentown, from Philadelphia County Society.

LUZERNE: *Transfers*—Anthony E. Chmielewski, Millville, N. J., to Cumberland County (N. J.) Society; Stanley J. Yamula, State Hospital, Hazleton, from Lehigh County Society.

McKEAN: *Transfer*—William J. Potts, Jr., Kane, from Erie County Society.

MONTGOMERY: *Transfers*—Sterling A. Mackinnon, Norristown, from Philadelphia County Society; Carroll F. Burgoon, Jr., Philadelphia, from Philadelphia County Society.

NORTHAMPTON: *Resignation*—Leslie S. Freeman, Bound Brook, N. J. *Transfer*—Richard S. Refowich, Bethlehem, from Philadelphia County Society.

PHILADELPHIA: *Transfer*—Joseph F. McCloskey, Philadelphia, from Lackawanna County Society.

SCHUYLKILL: *Deaths*—Lyman D. Heim, Schuylkill Haven (Jeff. Med. Coll. '03), September 19, aged 73; Raymond H. Stutzman, Tower City (Maryland Med. Coll. '12), September 25, aged 65.

WAYNE-PIKE: *Death*—Arno C. Voigt, Hawley (Jeff. Med. Coll. '01), September 21, aged 72.

WESTMORELAND: *Deaths*—Russell A. Garman, Jeanette (Jeff. Med. Coll. '30), October 1, aged 46; Louis F. Wilson, Greensburg (Univ. of Va. '01), June 29, aged 74.

YORK: *Resignation*—Arthur N. Barr, Welch, W. Va. *Death*—J. Nelson Dunnick, York (Balt. Med. Coll. '99), October 9, aged 78.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the Benevolence Fund. These have all been individually acknowledged previously.

Woman's Auxiliary, Adams County	\$25.00
Woman's Auxiliary, Beaver County	10.00
By Dr. and Mrs. Pettler in memory of Mrs. R. B. Brierly	
Woman's Auxiliary, Bucks County	5.00
Memory of Dr. J. E. Barsby	
Woman's Auxiliary, Cumberland County	5.00
Memory of Dr. N. W. Hershner, Sr.	
Woman's Auxiliary, Dauphin County	5.00
Memory of Mrs. George Hartman	
Woman's Auxiliary, Juniata County	5.00
Woman's Auxiliary, Montgomery County	20.00
By Mrs. W. J. Wright in memory of Mrs. Bertha White	
A friend (member of Philadelphia County Society)	10.00
Previously reported	35.00

Total contributions since 1950 report \$120.00

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since September 30. Figures in the first column denote county society numbers; second column, State Society numbers.

Oct. 3 Mercer	84	10340	\$23.00
Fayette	114	10341	11.50
Blair	119-121	10342-10344	69.00
6 Philadelphia	3070-3109	10345-10383	793.50
Erie	203	10384	11.50
10 Monroe	41	10385	11.50
11 Cambria	157	10386	23.00
Chester	119	10387	23.00
Lancaster	230	10388	11.50
Lehigh	224	10389	11.50
Bucks	92	10390	23.00
13 Washington	138	10391	11.50
20 Lancaster	231-236	10392-10397	69.00
Delaware	308-309	10398-10399	34.50
Indiana	42	10400	23.00

Oct. 20 Lackawanna	286-287	10401-10402	\$23.00
Montgomery	352-358	10403-10409	80.50
25 Delaware	310-311	10410-10411	46.00
Jefferson	58	10412	23.00
Luzerne	372-373	10413-10414	34.50
3 Montgomery	351	(Affiliate)	12.00

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The following requests were filled during the month of October:

Whipple's disease	Multiple sclerosis
Meckel's diverticulum	Socialized medicine (2)
Exercise	Rorschach test
Anxiety states	Histoplasmosis
Seminal vesiculitis	Leukoplakia

Pneumoperitoneum	Toxicity of beryllium
Alcoholics Anonymous	Epilepsy
Ulcerative colitis	Occupational dermatoses
Albinism	Psychiatric diseases
Pneumonia	Child psychology
Poliomyelitis	Neurofibromatosis
Treatment of migraine	Cancer of the ovary
Ventricular tachycardia	Senear-Usher syndrome
Circumcision	Aureomycin
Fluid balance	Correction of speech
Diverticuli of small intestine	
Technique of psychotherapy	
Acute reactive depression	
Carcinoma of the prostate	
Diagnosis and treatment of neurosyphilis	
Obstructive valve of the posterior urethra	
Alcohol and its effects on the body	
Pernicious anemia in pregnancy	
Glutamic acid in backward children and in mental deficiency	
Typhoid fever therapy in treatment of syphilis	
Carcinoma of both optic nerves	
Thumbsucking in children	
Pelvic neoplasms during pregnancy	
Community health ordinances	
Diverticulitis of small intestine	
Arteriographic examination of lower extremities	
Equipment for house calls	
Central nervous system diseases complicating pregnancy	
Reticular cell lymphosarcoma	
History and therapy of tuberculosis	
Glutamic acid in therapy of mongoloids	
Treatment of multiple sclerosis	
Studies on ACTH and cortisone	
Tumors of the optic nerve	
Physicians in the United States	
Care of crippled children	
Medical schools in Massachusetts	
Rubella and malformation	

AIR AMBULANCE SERVICE AVAILABLE

Air ambulances are now available to physicians in Pennsylvania to speed sick or injured to hospitals, according to a directory issued by the Civil Aeronautics Administration and distributed to all county medical societies and leading hospitals in the State.

Established primarily as an emergency mercy service, ambulance planes are based at ten airports, listed as follows: Allentown-Bethlehem-Easton Airport at Allentown; Wings Field, Ambler; Municipal Airport, DuBois; Port Erie Municipal Airport, Erie; Old Star Airport, Langhorne; Millard Airport, Palmyra; Allegheny County Airport, Pittsburgh; Salix Airport, Salix, Cambria County; York Continental Airways Airport and York Airport, York.

The charge for ambulance planes varies with the type of plane used and is based in most instances on an hourly rate. This information may be obtained from the airport.

The Civil Aeronautics Administration maintains at three Pennsylvania airports (Allentown, Harrisburg, and Pittsburgh) aviation safety agents whose concern is in bringing together the airplane operator and the person or organization in need of aerial ambulance service.

While many of the planes used in aerial ambulance service are small, larger planes are available (including B-17's and DC-3's) capable of accommodating many stretchers in addition to medical and nursing personnel. The larger planes may be called in for relief in emergencies such as floods, tornadoes, winter storms, and atomic disaster.

A copy of the current Directory of Ambulance Planes has been furnished to the secretary of each county medical society. Additional copies are available upon request to the office of the State Medical Society, 230 State St., Harrisburg, Pa.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the cooperation of the Pennsylvania Tuberculosis and Health Society and The Medical Society of the State of Pennsylvania

THE NUMBER of cases of unsuspected tuberculosis in the general population would be greatly reduced if physicians would require chest x-rays as a part of the routine examination of all private patients. Now, as always, the physician in private practice is a key figure in the control of tuberculosis.

CASE FINDING AMONG PRIVATE PATIENTS

It is recognized that there are many reasons for the rapid decline in the incidence of tuberculosis during the past 50 years. It is impossible to evaluate accurately, or even approximately, the relative influence of complex socio-economic conditions and of control measures in bringing about this favorable result.

In 1937, Wade H. Frost concluded that the point had been reached in the United States where there is a gradual downward trend in the incidence of tuberculosis, and that, barring major upsets in civilization, the eventual eradication of the disease can be expected. The continued decline in the annual number of deaths from tuberculosis during the past 12 years, in spite of the adverse conditions caused by a great war, is ground for confidence in the accuracy of Frost's conclusion.

Even though control measures are only one factor in the eradication of tuberculosis, they may very well be the decisive factor. Anything which will reduce the size of the reservoir of the tubercle bacillus in human beings will lessen the number of new cases of tuberculosis. Every case of the disease, actually or potentially infectious, which is discovered and brought under control is a step in reducing the size of this reservoir. In the aggregate, control measures may represent the weight which will tip the balance in favor of the human race. It is this consideration which gives importance to any method which discloses a considerable number of cases of tuberculosis, and especially of those which are symptomless.

Although statements to the contrary have been made recently, nothing is more completely proved than the fact that approximately one-half of all cases of significant tuberculosis have no symptoms, or symptoms so slight as to escape notice. According to the National Tuberculosis Association estimates, there are a quarter of a million unknown cases of tuberculosis in the United States—at least as many as there are known cases—and recent experience indicates that the unknown cases far outnumber the known. In the 1948 mass survey in Washington, D. C., 4098 out of 4665 cases of tuberculosis discovered were previously unknown to the health department. Similar findings have been reported in all other large surveys.

From its small beginnings during the decade 1930-40, the mass survey method for tuberculosis detection has advanced in the United States to the point where at present about 14 million people annually undergo chest x-ray examinations. This is a significant achievement, and although it can be extended until the equipment already existing is fully utilized, it still does not represent a case-finding rate sufficiently high to insure control of the disease in any reasonable time. It is important that the mass survey programs be enlarged, but, in the meantime, every method which promises disclosure of a considerable number of cases of tuberculosis should be utilized.

Sixty to eighty million Americans, for one reason or another, annually consult a doctor, and it is known that the tuberculosis rate among them



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—Council on Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. 143:815 (July 1) 1950.



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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

is much higher than among the general population. For this reason it is highly desirable that private physicians, including general practitioners, internists, and specialists, obtain a survey film of every patient who consults them unless the results of a recent chest x-ray survey are available.

It has been the practice of some radiologists for many years to make a single film of the chest in cases referred for other examinations, especially in cases referred for gastro-intestinal study. This has disclosed many unsuspected chest conditions including tuberculosis. Now that photo-fluorography has greatly reduced the cost of such a survey film, it should become routine practice among radiologists; its quite nominal cost can be absorbed in the major examination.

This reservoir of cases, however, is small compared with the vast number who consult general practitioners and internists. Methods can undoubtedly be devised whereby all such patients, at least those who are 15 years of age or older, can have a survey film made without cost to the patient—even a small charge would probably prevent wide use of the method. It is not necessary that any one method be adopted to accomplish the desired end. In some communities the local or state health department could, perhaps, defray the cost as part of the general tuberculosis prevention program, especially in view of the

fact that case finding in the smaller group would be relatively much more productive than in the usual mass survey. In other communities it could be done by the tuberculosis association. In still others, general hospitals which have adopted a hospital admission x-ray survey program could enlarge the program to include survey films for the private patients of members of the hospital staff. Furthermore, it could very well become general practice among radiologists to make available such service to the general profession.

The details of such a program may seem numerous and difficult at first thought, but they can be worked out. The first essential for its success is the interest of the private physicians of each community. They are in the best position to promote it and to carry it out.

Today, because of procedures which have become routine, the private physician's office is a bulwark against such diseases as smallpox and diphtheria. In like manner, it can become one of the most effective agencies for tuberculosis control. By promoting such a public health measure, the general practitioners of the nation would be acting in line with the great tradition of the profession as a force for prevention as well as cure of disease.

Case Finding Among Private Patients, A. C. Christie, M.D., Pub. Health Rep., June 2, 1950.

SHORTENING PAPERS

The need for the shortening of medical papers is the subject of an interesting editorial by Richard M. Hewitt appearing in *Radiology* for April, 1950. As he says, medical articles should frequently have all the excess words squeezed out of them, just as during the War foods had to be dehydrated so that they could be shipped to the front more cheaply.

The readers of medical journals want the shortest possible statements as to what the authors found or concluded. Often there is no need for stuffing the article with references to the writings of former workers. These writings are constantly being abstracted by writer after writer. What each man should have said was, "The literature on this subject was well reviewed by John Doe in ———." Very cleverly Hewitt says that the behavior of many medical writers is like that of a bunch of youngsters singing "Old MacDonald Had a Farm" or "Johnny Schmoker." Every time they give a new bit of information they include all that went before!

Very often a doctor writes his paper; then he sums

things up under the heading "comment," later he sums it up again in a "conclusion," and finally in a "summary." Once or twice is plenty.

All authors should remember that there is no use in writing unless the article is going to be read, and it is not likely to be read unless it is short and interesting. The man who would like to have his paper read must jump right into his subject with a very short preamble. Most men "preamble" so long and so dully that they lose their readers. These readers never get to the substance of the article.

The first sentence or two of an article should be so written as to grip the interest of the reader and show him why the article was written and what gap in knowledge it is supposed to fill. Once the writer has captured the interest of the reader, he should do his best to hang onto it and not let it go. He will let it go if at the start he puts in a lot of boring information about details of technique or what-not.

Often big tables and much description can be replaced by a simple graph. This will give the substance of the paper at a glance.—*GP*, November, 1950.

THE WOMAN'S AUXILIARY

MRS. PAUL C. CRAIG, *Editor*

232 North Fifth Street, Reading

PRESIDENT'S MESSAGE



The Wise Men from the East who followed the Star to Bethlehem and came to worship the Christ Child were consecrated religious men, pure in heart, in mind, and in deed, bringing princely gifts of gold, frankincense and myrrh to the newborn Christ, the Prince of Peace.

As I am writing my Christmas message to you, my fellow Auxiliary members, the tones of the Freedom Bell ringing in Berlin are being heard throughout all of the freedom-loving lands in the world. More than twenty centuries have passed since the birth of the Prince of Peace. The crusade for freedom may become in truth the return visit of the Wise Men—greatly increased in number, however, and including all of us who in sincere homage and consecration bring pure hearts, pure minds, and pure deeds toward the establishment and preservation in our time, this twentieth century, of Peace on Earth to Men and Women of Good Will.

I am thinking of all of you during this happy holiday season, and I extend greetings to you all and to your families, and good wishes for Christmas and the New Year and for the challenging and hopeful days to come.

Your devoted president,

(MRS. HOWARD H.) MARY STEEL HAMMAN.

SPECIAL THANKS

We are deeply indebted to the Philadelphia County Auxiliary for a beautifully executed convention. Special thanks and gratitude are here expressed to the convention chairmen—Mrs. Hugh Robertson and Mrs. Hugh McCauley Miller, and to all of their committee members, for giving us a meeting long to be remembered.

THE GAVEL CLUB ORGANIZES

On Oct. 17, 1950, the past presidents of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania and several invited guests met in the suite of Mrs. Drury Hinton, in the Bellevue-Stratford Hotel.

The meeting was called to order by all present, using gilded gavels adorned with red ribbon bows and red rose buds, but there was only disorder.

Present were past presidents—Hunsberger, Lyon, Griesemer, Donaldson, Crouse, Orthner, Swalm, Linn, Bierly, and Craig, and guests—Dwyer, Hancock, and Buyers.

A delicious supper was served. After a slight discussion, the name GAVEL CLUB was selected.

The nomination and election of officers were from the floor with many protests from those elected. Duly installed were: president, Mrs.



Gavel Club Organizers. Shown above are the past presidents of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania and guests who formed the club at the twenty-sixth annual convention of the Auxiliary. From left to right in the front row are Mrs. J. Newton Hunsberger, Mrs. Drury Hinton, Mrs. Edgar S. Buyers, Mrs. Francis P. Dwyer, Mrs. H. Morrison Hancock, and Mrs. Paul C. Craig; back row, Mrs. Rufus M. Bierly, Mrs. Walter J. Donaldson, Mrs. Walter Orthner, Mrs. Charles J. Swalm, Mrs. Jay G. Linn, Mrs. Charles C. Crouse, and Mrs. Wellington D. Griesemer.

Frank P. Dwyer; secretary, Mrs. Edgar S. Buyers; treasurer, Mrs. H. Morrison Hancock.

The hilarious meeting adjourned so that the club members could attend the Installation Meeting of The Medical Society of the State of Pennsylvania.

Respectfully submitted,

(MRS. EDGAR) MARY BUYERS, *Secretary*.

CONVENTION IN REVIEW

The auxiliary convention in Philadelphia, as developed by Mrs. Drury Hinton, state president, was so filled with interesting events that a detailed report is impossible. The minutes of the business meetings appear in this JOURNAL.

The Religious Service of The Medical Society of the State of Pennsylvania, held at Irvine Auditorium, University of Pennsylvania, on Sunday afternoon, October 15, was inspiring. The addresses by Dr. Bertram W. Korn, rabbi of Reformed Congregation Keneseth Israel, Rev. W. Hamilton Aulenbach, rector of Christ Church and St. Michael's, and by Dr. John S. Ladd Thomas, dean of the Theological School, Temple University, were preceded by an organ

recital by Joseph D. Chapline, Jr. Two anthems were beautifully sung by the Men's Glee Club of the University of Pennsylvania under the direction of Robert S. Godsall. Daughters of Auxiliary members served as ushers. A buffet supper was served at Houston Hall, University of Pennsylvania, following the service.

The opening day of the convention, Monday, October 16, was designated as "All Presidents' Day." The luncheon honored Mrs. Arthur A. Herold, president of the Woman's Auxiliary to the American Medical Association, Mrs. Drury Hinton, president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, and all county presidents who served with Mrs. Hinton during 1949-1950. Mrs. J. Fredrick Dreyer presided and Miss Mary Henry Stites gave the thanksgiving.

Mrs. Herold, speaking on "The Auxiliary and Its Opportunity for Service," emphasized particularly the need for each auxiliary member to be well informed on matters of legislation, health education, and public relations. She said that a poorly informed doctor's wife is a menace to the medical profession. Her charm, her wisdom, and her kindness were additional inspiration to all present.

Mrs. Hinton introduced all the district councilors and county presidents as well as the presidents of the auxiliaries of the neighboring states of New Jersey and West Virginia.

The formal opening of the convention followed. At the close of this session, a tea honoring past state presidents was held in the Mirage Room of the Barclay Hotel. Mrs. Howard H. Hamman, president-elect, presided and headed the receiving line which included Mrs. Herold and the following past presidents: Mrs. Edward Lyon, Mrs. Wellington D. Griesemer, Mrs. Walter F. Donaldson, Mrs. Charles C. Crouse, Mrs. Walter Orthner, Mrs. Charles J. Swalm, Mrs. Jay G. Linn, Mrs. Rufus M. Bierly, and Mrs. Paul C. Craig, and the retiring president, Mrs. Drury Hinton.

These directors of the State Auxiliary poured: Mrs. Andrew L. Benson, Mrs. Albert J. Blair, Mrs. E. Roger Samuel, Mrs. Adolphus Koenig, and Mrs. Frank J. Theuerkauf. A program of vocal selections was given by Mary de Prophetis, soprano.

Many auxiliary members attended the third annual State Dinner of the Medical Society on Monday evening to hear Dr. George F. Lull and to enjoy an hour of entertainment. Auxiliary

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CONTEST ENDS JANUARY 31, 1951

representatives at the speakers' table were Mrs. Hinton, Mrs. Herold, Mrs. Hamman, and Mrs. Frank B. Lynch, president of the Philadelphia Auxiliary.

On Tuesday morning members interested in animal research legislation, and each member should be, heard much of interest in the panel discussion on this topic. It seems almost unbelievable when one knows the advantages to humanity that have been gained medically and surgically in the research laboratories that anyone could oppose a bill which would permit medical schools to buy unclaimed dogs held in pounds for ten days. At the present time in Philadelphia between 15,000 and 20,000 dogs are killed in gas chambers annually because the law forbids their use to save human lives. It was emphasized by each speaker that animal research education should play an important part in the coming year's activity for all auxiliary members.

At the Tuesday luncheon Mrs. Albert F. Doyle introduced the guests of honor: E. Roger Samuel, M.D., president of The Medical Society of the State of Pennsylvania, Howard K. Petry, M.D., chairman of the Advisory Committee to the Woman's Auxiliary, and other guests.

An address entitled "Students of Liberty" was delivered by Mr. Leonard E. Read, president of the Foundation for Economic Education. Mr. Read's interpretation of Communism or Statism versus Liberty was thought-provoking and delightfully new in its approach. He stressed the need of some form of religious belief or thought for everyone and the courage and strength to cling to that belief.

General business sessions continued on Tuesday afternoon and Wednesday morning. Preceding the installation of the new officers, Mrs. W. Wayne Babcock, our newest honorary mem-

ber, described the difficulties encountered when early efforts were made to organize the Auxiliary, which included vehement opposition by members of the Medical Society. Her remarks led Mrs. Hinton to state that perhaps the present problems are more easily solved because of the wholehearted support of the doctors.

Following adjournment, three buses filled with auxiliary members left for an outing at Longwood Gardens. It was a typical Indian Summer day. A delicious luncheon was served at the Kennett Square Country Club, with members of the Chester County Auxiliary acting as hostesses.

A reception and dance honoring the incoming president of the Medical Society, Harold B. Gardner, M.D., concluded the Wednesday schedule.

All the meetings of the convention were well attended. It is hoped that each person who was there will remember the highlights in addition to those included in this summary.

The Woman's Auxiliary to the Philadelphia County Medical Society enjoyed having each auxiliary member as a guest. May the memories of the Philadelphia sessions be pleasant!

MRS. JOHN H. WILLARD,
Philadelphia County Convention
Publicity Chairman.

CONVENTION MINUTES

The twenty-sixth annual convention of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania was called to order by the president, Mrs. Drury Hinton of Drexel Hill, at 3 p.m. Monday, Oct. 16, 1950, at the Bellevue-Stratford Hotel in Philadelphia. Mrs. Ralston O. Gettemy, of Altoona, asked

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Divine guidance for the meetings. Mrs. Arthur A. Herold, of Shreveport, La., president of the Auxiliary to the American Medical Association, led the convention in the Pledge of Loyalty.

Dr. George F. Lull, secretary of the American Medical Association, brought greetings to the Pennsylvania Auxiliary. He asked for help in the personal contact program planned by the American Medical Association and urged convention members to see that their families and friends voted in November.

Dr. Henry B. Kobler and Mrs. Frank B. Lynch, of Philadelphia, welcomed the convention to Philadelphia, and Mrs. Joseph E. Shelby, of Uniontown, responded to the welcomes.

Mrs. William A. Shannon, of Philadelphia, gave a report of the American Medical Association convention in San Francisco in June, 1950.

The report of the nominating committee was posted in the meeting place by the chairman, Mrs. Paul C. Craig, of Reading.

Thirty-nine counties were represented at the opening session and 199 members registered the first day.

The second session of the convention opened Tuesday, October 17, at 9:15 a.m. The finance report was read by the chairman, Mrs. Rufus M. Bierly, of West Pittston, and the auditors' report read by the secretary was ordered filed.

Mrs. William Bates, of Philadelphia, read the new by-laws prepared by her committee, section by section. The entire list was accepted unanimously after discussion on only one section, Article X, by Philadelphia members.

Mrs. H. Morrison Hancock conducted an impressive In Memoriam service for 17 members who had passed on since the last convention. Music for the service was provided by Mrs. Virginia Kendrick Clark, a member of the Philadelphia Auxiliary.

Forty-three counties were represented at roll call at this time, and 248 members were registered.

A panel discussion on "Animal Research" was conducted by Mr. Leo E. Brown, of Harrisburg, executive assistant of the State Society Committee on Public Relations, and Mr. Ralph A. Rohweder of Chicago, executive secretary of the National Society for Medical Research. Pending legislation was discussed and the need for such legislation was impressively presented. Dr. J. Parsons Schaeffer, of Philadelphia, chairman of the Commission on Defense of (since changed to Promotion of) Animal Research of the State Medical Society, gave a résumé of the actual work in animal research as carried on in the laboratories. General discussion followed the panel.

The second session adjourned at 12 Noon for a luncheon in honor of the Advisory Committee to the Woman's Auxiliary and other guests from The Medical Society of the State of Pennsylvania.

The third session of the convention convened at 3 p.m., October 17. It was voted that an expression of the Auxiliary's appreciation for many and varied kindnesses be sent to the trustees of The Medical Society of the State of Pennsylvania.

A quiz program, "Stumping the Experts," followed. Members asked state chairmen many questions on routine committee work in benevolence, *Today's Health*,

legislation, publicity, *National Bulletin*, and public relations. Mrs. Arthur A. Herold, president of the Auxiliary to the American Medical Association, answered questions on many subjects.

The annual auxiliary contribution to medical benevolence from the counties amounted to \$10,373.77 for 1949-50.

Mrs. John V. Foster, Jr., of Harrisburg, announced the winners of the poster awards. The awards went to high school and grade school students after the assembled posters were carefully judged. The youthful winners of the top awards were guests at the annual State Dinner of the Medical Society, October 16.

The registration committee announced a total of 312 members registered before the third session.

Questionnaires from the Mid-Year Conference on conference dates and regional meetings were evaluated by Mrs. J. Frederick Dreyer, of Allentown. The result showed a preference for an April meeting instead of March and for three regional conferences rather than one. No action was taken on this matter.

Mrs. Frank J. Corbett read the courtesy resolutions prepared by her committee.

Thirty-three members of the Auxiliary were elected to serve as delegates at the annual convention of the Auxiliary to the American Medical Association to be held in Atlantic City in June, 1951.

The past presidents met for dinner with Mrs. Hinton, and the county presidents, presidents-elect, and councilors met for dinner with Mrs. Howard H. Hamman of Greensburg, president-elect, after the adjourned session.

The fourth session of the convention convened at 9:15 a.m., October 18.

Mrs. Paul C. Craig presented a resolution, which was unanimously approved, to make Mrs. W. Wayne Babcock, of Philadelphia, an honorary member of the State Auxiliary. Mrs. Babcock was the organizer of the Auxiliary in Pennsylvania in 1924, and gave the organization many years of outstanding service. She was presented a gift from the Auxiliary by Mrs. Francis P. Dwyer, of Renovo. It was an antique gold brooch engraved 1924-1950.

The final report of the credentials and registration committee showed 357 members registered.

Mrs. Paul C. Craig gave the report of the committee on nominations, and the entire slate was declared elected as presented when there were no further nominations from the floor. The new slate is as follows:

President-elect—Mrs. Albert F. Doyle, Cambria County, Eleventh District.

First vice-president—Mrs. J. Frederick Dreyer, Lehigh County, Second District.

Second vice-president—Mrs. Andrew L. Benson, Clearfield County, Sixth District.

Third vice-president—Mrs. James F. Elder, Mercer County, Eighth District.

Recording secretary—Mrs. Francis P. Dwyer, Clinton County, Seventh District.

Treasurer—Mrs. Edmund C. Boots, Allegheny County, Tenth District.

Directors (two-year term): Mrs. John V. Foster, Jr., Dauphin County, Fifth District; Mrs. Daniel O'Con-



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nell, Westmoreland County, Tenth District; Mrs. Charles L. Shafer, Luzerne County, Twelfth District.

Councilors (three-year term): Mrs. Saul Steinberg, Montgomery County, Second District; Mrs. Samuel L. Woodhouse, Jr., Mifflin County, Sixth District; Mrs. Ralph M. Tidd, Jr., Erie County, Eighth District; Mrs. Joseph E. Shelby, Fayette County, Eleventh District.

Mrs. Craig conducted the installation ceremonies. Mrs. Howard H. Hamman, of Greensburg, became the twenty-seventh president of the Auxiliary when she was given the gavel of authority and the president's pin by Mrs. Hinton. Mrs. Jay G. Linn, of Pittsburgh, presented the traditional past president's pin to Mrs. Hinton.

Dr. Drury Hinton welcomed home his wife by coming to the convention prepared with cookies and cakes he had learned to make during his two years of sharing his wife with the Auxiliary. He initiated Dr. Hamman into the secrets of life in an auxiliary president's home.

Mrs. Hamman gave an outline of her plans for the Auxiliary in 1950-1951 and presented her committee chairmen to the convention.

The formal meeting of the twenty-sixth convention adjourned at 11 a.m., October 18, to meet again at Kennett Square at 1 p.m. for an outing.

MRS. DRURY HINTON, *President,*

MRS. FRANCIS P. DWYER, *Secretary.*



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NEWS FROM THE COUNTIES

ALLEGHENY, celebrating its silver anniversary, and closing a successful year under the leadership of Mrs. Lester L. Bartlett, gave pins to the past presidents. (Note: these were designed by Olivia Koenig, daughter of the fifty-sixth president of The Medical Society of the State of Pennsylvania and sister of a physician, who also designed the beautiful pin which the president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania wears.) Under the guidance of Mrs. Allison J. Berlin, a benefit luncheon-bridge and fashion show netted proceeds which made it possible for this county to give \$1,385.37 to the medical benevolence fund. The new president, Mrs. Horace E. DeWalt, ably represented the auxiliary when she was invited to join a selected group of Pittsburgh women who attended the United Nations Assembly and the *Herald Tribune* forum in New York in October.

FAYETTE, meeting in September at the home of Mrs. Thomas E. Park, with Mrs. Edwin S. Peters presiding, reported that its project for the year is to aid the lepers. This is to be done by saving pennies in small "piggy" banks. A resolution against socialized medicine was adopted. This auxiliary has also asked its medical society to set up a speakers' bureau.

LEHIGH'S president, Mrs. Ralph F. Harwick, is gratified that her group has made contributions to the Community Chest and to Girls Haven, has sponsored a well-attended fashion show, and heard a stimulating talk on "The Old Home Town," a history of Allentown dating back to 1763.



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LYCOMING and BERKS members were busy this fall manning the exhibit on animal research at their respective county fairs.

INDIANA held its September meeting at the home of Mrs. Harry B. Neal with Mrs. Warren L. Whitten, president, conducting a business session.

MIFFLIN invited JUNIATA auxiliary to its October luncheon. Mrs. John R. W. Hunter, Jr., took charge of the meeting. The publicity questionnaire about auxiliary pages in the PENNSYLVANIA MEDICAL JOURNAL and the *KEYSTONE FORMULA* were discussed. An instructive question period on socialized medicine was a feature. Mrs. S. Lawrence Woodhouse, new Sixth District councilor, gave a splendid report of the Philadelphia convention.

MONTGOMERY, meeting in October with Mrs. John M. Brecht presiding, enjoyed a skit written and produced by a member, Mrs. William C. Bown, entitled "Aunt Jennie Looks at Her Album."

NORTHAMPTON held a fall luncheon with its president, Mrs. Melvin M. Berger, leading a discussion of plans for the year.

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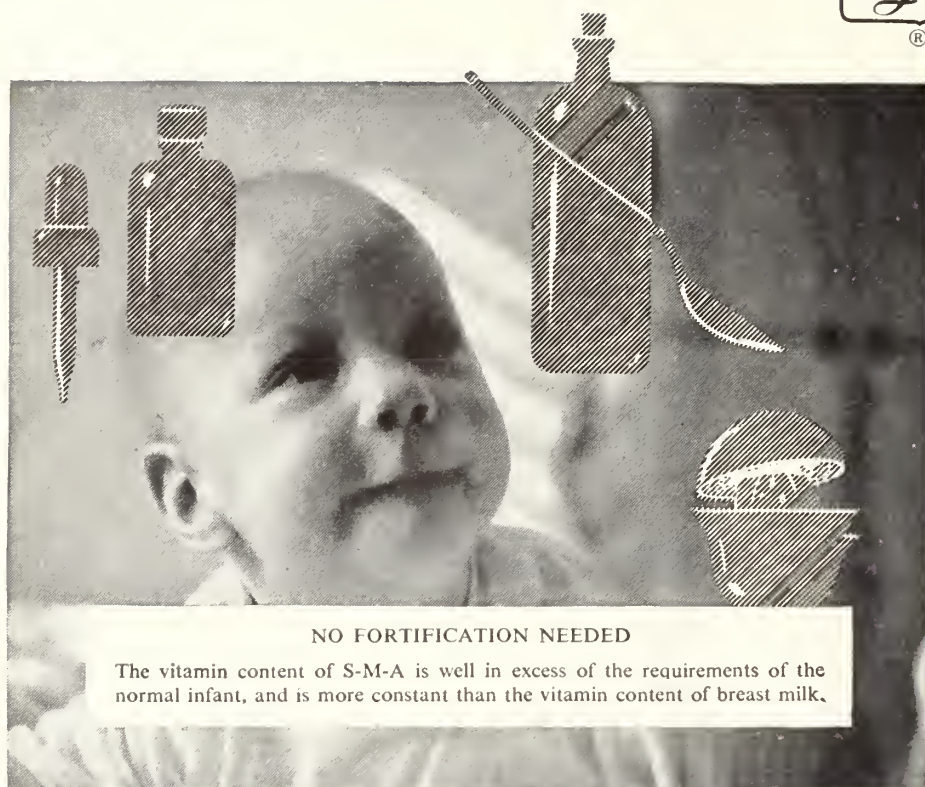
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1. Bauer, G., *Angiology* 1: 161-169 (Apr.) 1950.

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MEDICAL NEWS

Birth

TO ALICE L. RALPH, M.D., and Nathan Ralph, M.D., of Philadelphia, a son, Jonathan Daniel Ralph, November 14.

Engagements

MISS JOSEPHINE ROSE GRANT, of Los Angeles, to Leonard E. Lecks, M.D., of Philadelphia.

MISS JANE COREY STONE, of Jenkintown, to Alvin Michael Soffe, M.D., of Philadelphia.

MISS BELLE WERDEN, of Jenkintown, to Mr. Wilson Lear Miller, son of Dr. and Mrs. Hugh McCauley Miller, of Wyncote.

MISS JEAN ELIZABETH HILL to Mr. Charles C. Chapple, Jr., son of Dr. and Mrs. Charles C. Chapple, all of Philadelphia.

MISS SUE ELLEN ARONSHON, of New York, to Mano Robert Golden, M.D., son of Dr. and Mrs. Louis M. Golden, of Philadelphia.

MISS NANCY NEWBERRY DOWNES, of Alexandria, Va., to Mr. David Hammond Means, son of Dr. and Mrs. William Horace Means, of Lebanon.

MISS FLORENCE E. STEWART, of Rosemont, to Mr. Alfred E. Krick, Jr., son of Dr. Alfred E. Krick and Mrs. Edna V. Higgins, of Philadelphia.

MISS PATRICIA ANN JONES, daughter of Dr. and Mrs. Harold W. Jones, of Wynnewood, to Mr. James P. Lewis, Jr., son of Dr. and Mrs. James P. Lewis, also of Wynnewood.

MISS MARGARET ANNE HILL to Mr. Ronald Tocantins, son of Dr. and Mrs. Leandro M. Tocantins, all of Philadelphia. Mr. Tocantins is attending Jefferson Medical College.

MISS DOROTHY MAE MARK, of Riverton, N. J., to Mr. John William Arbogast, Jr., son of Dr. and Mrs. John W. Arbogast, of Lewisburg. Mr. Arbogast is a senior at Temple University Medical School.

Marriages

DR. GLADYS LONDON, of Philadelphia, to Samuel P. Ivins, M.D., of Chester, November 16.

MARY JANE STERN, M.D., of Edinboro, to Mr. Edwin John Hedlund, Jr., of Erie, November 15.

MISS MARIE PATRICIA ADAMS to Joseph Franklin Kraika, M.D., both of Philadelphia, October 11.

MISS HILDA DAROFF to Armand L. Rosenbaum, M.D., son of Dr. and Mrs. George Rosenbaum, all of Philadelphia, December 3.

MISS NANCY RUTH BISHOP, of Milroy, to John Denney Farquhar, M.D., son of Dr. and Mrs. John W. Farquhar, of California, October 28.

MISS BETTY ANN CAMP, of Haverford, to Mr. Harry L. Masters, Jr., son of Dr. and Mrs. Harry L. Masters, of White Mills, November 18.

MISS KATHERINE ELLEN DILLON, of Philadelphia, to James Patrick Scanlon, M.D., of Philadelphia and Washington, D. C., November 23.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ Elmer E. Wible, Karns City; University of Pittsburgh School of Medicine, 1891; aged 83; died Nov. 20, 1950, at the home of his son. Dr. Wible had practiced medicine in the Pittsburgh and Homestead districts for almost a half century. He retired from active practice several years ago. In 1907 Dr. Wible took graduate work in London and Vienna. He was a former member of the staff of Eye and Ear and Columbia Hospitals, and was one of the founders and a staff member of Homestead Hospital. From 1918 to 1922 he was treasurer of the Allegheny County Medical Society. Besides his son, he leaves two daughters.

Harry B. Burns, Ligonier; Bellevue Hospital Medical College, New York, 1895; aged 79; died Nov. 22, 1950. Dr. Burns, in 1914, organized the health and physical education program of the Pittsburgh public school system, and during his 30 years of service Pittsburgh schools gained national recognition in the field of health education. He was also Pittsburgh's chief medical inspector and director of the Bureau of Child Welfare during the Magee administration. He retired in 1940. Survivors are his widow, two daughters, and a son.

○ Samuel A. Savitz, Philadelphia; Medico-Chirurgical College of Philadelphia, 1905; aged 66; died of a heart attack Nov. 30, 1950. Dr. Savitz was a widower and had retired from practice eight years ago. He was assistant medical director of the U. S. Coast and Geodetic Survey in Alaska in 1909 and 1910. He served on the staffs of Mt. Sinai, Temple University, Jefferson, and Philadelphia General Hospitals, and until his retirement was associate professor of medicine at Temple. Surviving are two sons, a brother, and three sisters.

○ Frank B. Stevenson, Indiana; Jefferson Medical College of Philadelphia, 1908; aged 68; died Oct. 31, 1950. Dr. Stevenson established an eye, ear, nose and throat hospital in Indiana, and was a member of the medical staff of Indiana Memorial Hospital. He was the founder and first president of the Eye, Ear, Nose and Throat Society of Western Pennsylvania. During World War I, he served in the Army Medical Corps. He is survived by his widow, a son, two sisters, and one brother.

○ Paul E. Schwarz, Easton; Jefferson Medical College of Philadelphia, 1913; aged 59; died Nov. 18.

1950, of a heart attack at his home while watching a football game on television. Dr. Schwarz was chief of traumatic surgery at Easton Hospital for more than 20 years, and was also an Easton school physician. He was a former president of the Northampton County Medical Society. Surviving are his widow, two daughters, eight brothers, and two sisters.

Herman Trager, Seattle, Wash.; University of Pennsylvania School of Medicine, 1911; aged 64; died Nov. 28, 1950. Dr. Trager was an inspector with the Philadelphia Bureau of Health for many years until his retirement in 1946, when he moved to Seattle to become associated with the Veterans Administration. He was a captain in the Army Medical Corps during World War I. Surviving are his widow, a son, a daughter, a sister, and a brother.

○ Mario Polanco, Upper Darby; University of Pennsylvania School of Medicine, 1928; aged 48; died Nov. 8, 1950, at his home in Drexel Hill. Born in Puerto Rico, Dr. Polanco was chief visiting physician at Fitzgerald Mercy Hospital. From 1931 to 1934 he was chief of the medical clinic at Misericordia Hospital. Recently he had been associate gastro-enterologist at Jewish Hospital. His widow and a sister survive.

○ Frank G. Scharmann, Johnstown; Jefferson Medical College of Philadelphia, 1914; aged 59; died Nov. 14, 1950. He was a member of the Memorial Hospital staff and served as an attending roentgenologist. During World War I, he served in a base hospital overseas and attained the rank of captain. He was a former vice-president and secretary of the Cambria County Medical Society.

Samuel B. Ross, Philadelphia; Baltimore Medical College, Maryland, 1912; aged 66; died in October, 1950, following a heart attack. During World War I, he served overseas, and at the conclusion of the war he served in Russia for several years as a member of the Hoover Commission. He retired several years ago. Two brothers survive.

○ DeLorme T. Fordyce, Conshohocken; Temple University School of Medicine, 1911; aged 69; died suddenly Nov. 6, 1950. Dr. Fordyce formerly was chief of the eye clinic at Bryn Mawr Hospital for 20 years, and was a staff surgeon at Wills Eye Hospital for 20 years. He is survived by his widow, a son, a sister, and a brother.

○ Simon Seegman, Pittsburgh; University of Pittsburgh School of Medicine, 1902; aged 68; died Nov. 6, 1950, in Montefiore Hospital, where he was a former chief of staff. A nose and throat specialist, Dr. Seegman had studied in Vienna and Berlin. He is survived by two daughters, one brother, and three sisters.

○ Robert A. Marquis, Monaca; Hahnemann Medical College and Hospital of Philadelphia, 1936; aged 46; died Nov. 12, 1950. During World War II, he served as a lieutenant commander in the Navy for 22 months in the Pacific area. Surviving are his widow, a daughter, a son, his parents, and a brother.

○ J. Nelson Dunnick, York; Baltimore Medical College, Maryland, 1899; aged 78; died Oct. 9, 1950, after a brief illness. In 1949 he was honored by the State

Medical Society for having practiced medicine 50 years. He is survived by his widow, one son, and two daughters.

Wahler M. Barber, Grove City; Jefferson Medical College of Philadelphia, 1882; aged 92; died Nov. 12, 1950, following a ten-day illness. Dr. Barber had practiced medicine for 55 years before retiring. He is survived by his widow, two daughters, and a brother.

○ John J. Kolski, Pittsburgh; Medico-Chirurgical College of Philadelphia, 1911; aged 63; died Nov. 19, 1950. Dr. Kolski was on the staff of South Side Hospital. He is survived by his widow, three daughters, a son, a brother, and a sister.

○ William W. McFarland, Berkeley Springs, W. Va.; University of Pennsylvania School of Medicine, 1902; aged 72; died Oct. 14, 1950. A former Director of Health in the city of Pittsburgh, Dr. McFarland practiced in that city until 1948. He was retired.

Minnie Stryker, Philadelphia; Woman's Medical College of Pennsylvania, 1898; aged 81; died Nov. 27, 1950. Dr. Stryker, who was retired, had practiced medicine for 50 years.

Miscellaneous

THE ANNUAL CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY will be held March 6 to 9 at the Palmer House, Chicago, Ill.

THE TWENTY-THIRD ANNUAL CONVENTION OF THE AMERICAN SOCIETY OF X-RAY TECHNICIANS will be held at the Benjamin Franklin Hotel, Philadelphia, June 3 to 8, 1951.

FRANCIS J. CONAHAN, M.D., of Bethlehem, trustee and councilor of the Third Councilor District of the State Medical Society, was recently elected president of the Board of Directors of the Bethlehem Council of Social Agencies.

GEORGE S. KLUMP, M.D., of Williamsport, recently received "The Award of Merit of the Pennsylvania Public Health Association" from that association in recognition of his "untiring and forceful efforts and accomplishments in the procurement of better health facilities for the people of the Commonwealth."

THE WASHINGTON *Times Herald* carried the following London, November 9 (CTPS) item:

"Eleven thousand tuberculosis patients are waiting for beds in Britain's state-owned hospitals, the health ministry admitted today, following medical warnings that lack of institutional treatment was causing the disease to spread."

RICHARD A. KERN, M.D., of Philadelphia, professor and head of the Department of Medicine, Temple University School of Medicine, has been named editor of the *American Journal of the Medical Sciences*. Drs. Thomas M. Durant and Chris J. D. Zarafonetis, both of Temple, will serve with Dr. Kern as associate editor and assistant editor respectively.

CANDIDATES FOR THE CERTIFICATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY are accepted for examination on the evidence of a written qualifying test. These tests are held annually, in January, in various parts of the United States. *Applications are now being accepted* for the 1952 written test. Applications for the 1952 written test must be filed before July 1 and can be obtained by writing to the American Board of Ophthalmology, 56 Ivie Road, Cape Cottage, Maine.

THE 108TH MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held November 15 at the Wyomissing Club, Reading. Harvey E. Thorpe, M.D., chief of the Department of Ophthalmology, Montefiore Hospital, Pittsburgh, spoke on the subject of "Management of Intra-ocular Foreign Bodies." Also, a study club was conducted on the subject of "Management of Early Deafness." Instructors were James E. Landis, M.D., of Reading, and C. Fremont Hall, M.D., of Phoenixville.

DR. JOHN M. BUCHANAN, associate professor of physiologic chemistry in the School of Medicine of the University of Pennsylvania, Philadelphia, is the winner this year of the \$1,000 Eli Lilly & Company award in biological chemistry, with gold medal. The award was made under the auspices of the American Chemical Society. The citation accompanying the award commends Dr. Buchanan and his associates for their researches in connection with uric acid. The latter is said to be one of the most important constituents that make up the nucleus of the cell, and its presence in the tissues of the body is believed to play an important part in cellular growth.

THE BOARD OF TRUSTEES OF JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA received and accepted with great regret the resignation of William Harvey Perkins, M.D., as dean of the college. Dr. Perkins stated that due to the condition of his health he did not feel that he could continue to carry on the arduous duties as



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dean of this very large Philadelphia medical school.

In addition to being dean, Dr. Perkins has held the position on the faculty of professor of preventive medicine and head of the department. Dr. Perkins will continue on the faculty in this capacity.

The Board of Trustees also has announced the selection and appointment of George Allen Bennett, M.D., as dean. Dr. Bennett is at present professor of anatomy, head of the department, and director of the Daniel Baugh Institute of Anatomy, a position he will continue to hold.

CLASSIFIED ADVERTISEMENTS

Classified advertisements are payable in advance. To avoid delay in publishing, remit with order.

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For Sale.—Kelley-Koett double-x table with Bucky, fluoroscope and tube with 16 foot cables. Heavy duty rail-mounted tube stand, thermax double focus tube with 16 foot cables. Synchronous timer 1/10 to 14 seconds. Write Dr. R. MUSCHLITZ, Slatington, Pa.

Wanted.—Young general practitioner for Protestant community of 1500 located in Snyder County. Agricultural and industrial area. Office and housing made available. Civic leaders interested in securing physician. Write Dept. 221, PENNSYLVANIA MEDICAL JOURNAL.

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Wanted.—At once, medical doctor with Pennsylvania license to assist in hospital and outpatient department service of 120-bed institution. Desirable location. Ideal for a doctor desiring regular hours. Contact Dr. GEORGE F. WHEELER, Medical Director, Windber Hospital, Windber, Pa.

Residency Available.—Anesthesiology residency starting January 1, Board approved training. All phases of clinical anesthesiology; only graduates of approved medical schools accepted. Apply to ANTHONY T. ROSE, M.D., Director of Anesthesiology, Mt. Sinai Hospital, Philadelphia 47, Pa.

Wanted.—General practitioner for assistant to well-established and older Fellow of the American College of Surgeons. Married man desired. Good hospital facilities. Salary for first six months, then percentage. Apartment available in suburban area of twin cities. Great future. Minnesota license or national boards necessary. Write Dept. 207, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Doctor's residence with offices, located in north central Pennsylvania industrial town having drawing population of about 4000. Retiring after 27 years' practice. Hospital 26 miles distant. Residence suitable for specialized hospital as it once was before being remodeled into residence. Complete apartment in residence for extra tenant. Write Dept. 222, PENNSYLVANIA MEDICAL JOURNAL.

STORY BEHIND MEDICAL WORDS

Coroner. A contraction or corruption of the word crowner, which is the old and proper spelling. It formerly designated an officer acting for the interest of the Crown in England. A coroner now is a county officer whose duty it is to inquire into the causes of violent or sudden deaths.

Formication. A sensation resembling that caused by ants creeping or crawling on the skin. It is a descriptive term and is derived from the Latin word formica, the ant.

Egophony. This form of modified vocal resonance was described and named by Laennec. The term is peculiarly descriptive and is derived from the Greek words "aix" or goat and "phone" or voice. It consists of a wavering nasal tone not unlike the bleating of a goat.

Abduct. A term descriptive of the function or action. It literally means to draw or lead away from and is derived from the Latin ab, or from, plus ducere, to lead or draw.

Androgen. The name of this male sex hormone literally means man-maker. It is derived from the Greek words "aner" or man and "genesthai" to make or be produced.—HARRY WAIN, M.D., Mansfield, Ohio, in *Ohio State Medical Journal*.

NEW APPOINTMENTS AT PITT

Dr. William S. McEllroy, dean of the Medical School of the University of Pittsburgh, has announced the appointment of three psychiatrists to head up the university's new program in psychiatry and mental health.

Dr. Henry W. Brosin, professor of psychiatry and head of the division of psychiatry at the University of Chicago Medical School, has been named medical director of the university's Western Psychiatric Institute and Clinic. He will also hold the title of professor and head of the department of psychiatry in the university's School of Medicine.

Dr. Benjamin Spock, distinguished authority on child development and preventive mental hygiene, from Mayo Clinic and the University of Minnesota, will be professor of child development, with appointments in the department of pediatrics at Children's Hospital, the Child Guidance Center, and the Graduate School of Public Health.

Dr. I. Arthur Mirsky, associate professor of experimental medicine in psychiatry at the University of Cincinnati's School of Medicine and director of the May Institute at Cincinnati, will head the research division of the Psychiatric Institute which will aim at correlating biologic changes to emotion and psychiatric disorders.

The program and appointment of Drs. Brosin, Spock, and Mirsky have been made possible by a working agreement between the University and the Commonwealth of Pennsylvania and the Maurice and Laura Falk Foundation. It is expected that the program will cost approximately \$1,650,000 a year. It will center in the Western Psychiatric Institute and Clinic.

BOOK REVIEWS

Amusing Quotations for Doctors and Patients. Edited by Noah D. Fabricant, M.D. New York: Grune & Stratton, Inc., 1950. Price, \$3.00.

One man's meat is another man's poison, and likewise what is amusing to one may be boresome to another. One cannot quote Irvin S. Cobb, Mark Twain, and Wilson Mizner without coming up with some remarks that are sure to amuse everybody. But it is equally true that one cannot quote much of Balzac, who ridiculed the medical profession, without making some people mad. Dr. Fabricant has quoted all of these—and many more, but he has missed the diagnosis—they are not all amusing quotations. Quotations are listed alphabetically under such headings as "belly," "body-snatcher," "buttocks," and "constipation," which will give one an idea of the type of humor recommended by him for doctors and patients alike.

The Practice of Medicine. By Jonathan Campbell Meakins, C.B.E., M.D., LL.D., D.Sc., formerly Professor of Medicine and Director of the Department of Medicine, McGill University; formerly Physician-in-Chief, Royal Victoria Hospital, Montreal; formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Fellow of the Royal Society of Edinburgh; Fellow of the Royal Society of Canada; Fellow of the Royal College of Physicians, London; Fellow of the Royal College of Physicians, Edinburgh; Honorary Fellow of the Royal College of Surgeons, Edinburgh; Fellow of the Royal College of Physicians, Canada; Fellow of the American College of Physicians; Honorary Fellow of the Royal Society of Medicine. Fifth edition. With 518 illustrations including 50 in color. St. Louis: The C. V. Mosby Company, 1950. Price, \$13.50.

Dr. Meakins, in the preface to this fifth edition, states: "The task of writing a new edition of *The Practice of Medicine* is becoming increasingly difficult." That is almost an understatement, for to followers of Dr. Meakins' monumental work it is increasingly difficult to understand how one man can keep abreast of all that is new in medicine and correlate it all into one comprehensive volume. Notable additions over earlier editions include a new chapter on the antibiotics and chemotherapy and a chapter on psychosomatic medicine to replace the former small section on psychiatry. The sections on metabolism and on the ductless glands have been expanded with much new writing. Special atten-

tion has been given to the so-called collagen diseases, especially in regard to periarteritis nodosa, lupus erythematosus, and scleroderma. The book is a complete diagnostic and therapeutic guide for both specialist and general practitioner. If Dr. Meakins plans a sixth edition, it might well be in two volumes; the current one is compact, but heavy.

Progress in Gynecology. Volume II. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School; Chief of Staff of the Vincent Memorial Hospital and the Gynecologic Service of the Massachusetts General Hospital; Surgeon, Pondville Hospital; Gynecologist, Palmer Memorial Hospital; and Somers H. Sturgis, M.D., Clinical Associate in Gynecology, Harvard Medical School; Assistant Surgeon, Massachusetts General Hospital, Boston, Mass. New York: Grune & Stratton, 1950. Price, \$9.50.

This second edition or volume II, as designated by the authors, has been extensively revised with the addition of 22 new chapters. Several chapters have been deleted, so that their replacement by a larger number by different contributors has increased the size of the volume from 552 pages to an impressive one of 830.

The new volume consists of contributions of 78 eminent authors discussing all the latest developments in medical and surgical gynecology, clinical and laboratory endocrinology, and allied subjects. The only apparent omission, as noted by the authors, is the subject of ACTH as related to gynecology, a topic which undoubtedly will be considered in a future volume. The new chapters deal with such topics as ovarian neoplasms with endocrine activity, metabolism of the endometrium, congenital ovarian aplasia, salpingography, artificial insemination, ectopic pregnancy, hydatidiform mole and chorio-epithelioma, infected abortion, treatment of ovarian and uterine cancer, and treatment of stress incontinence of urine.

The chapters on the management of prolapse of the uterus and vagina and on vaginal hysterectomy have been entirely rewritten and decidedly improved with the addition of many illustrations. A new chapter dealing with radical hysterectomy for cancer of the cervix (Wertheim operation) by one of the editors is also well illustrated and is an excellent addition to the volume. There is also a chapter with illustrations con-

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The book is well bound and printed with practically none of the typographical errors carried over from the original volume. Many chapters have appended bibliographies of the subjects under discussion, which are of great value to the student. Because of the entirely new chapters added to the volume, it should be of great value to those readers who already possess Volume I.

The book abounds in concrete information for the young gynecologist just embarking on his career as

well as for the seasoned specialist. The many chapters dealing with the diagnosis and detailed treatment of various gynecologic and endocrinologic disorders make this volume an excellent aid to the general practitioner in his management of disorders of the female patient.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

Principles and Practice of Surgery. By Jacob K. Ber-
man, A.B., M.D., F.A.C.S., Indianapolis, Ind., Associate
Professor of Surgery, Indiana University School of
Medicine; Associate Professor of Oral Surgery, In-
diana University School of Dentistry; Chief Consult-
ant in Surgery, Billing's Veterans Administration Hos-
pital, Fort Benjamin Harrison, Indiana; Director of
Surgical Education and Surgical Research, Indianap-
olis General Hospital. With 429 illustrations. St. Louis:
The C. V. Mosby Company, 1950. Price, \$15.00.

Pediatric X-Ray Diagnosis. A textbook for students
and practitioners of pediatrics, surgery, and radiology.
By John Caffey, A.B., M.D., Professor of Clinical
Pediatrics, College of Physicians and Surgeons, Colum-
bia University; Attending Pediatrician and Roentgen-
ologist, Babies Hospital and Vanderbilt Clinic, New
York City; Consulting Pediatrician, Grasslands Hos-
pital, Westchester County, New York, and New Ro-
chelle Hospital, New Rochelle, N. Y.; Consulting
Roentgenologist, Orange Memorial Hospital, Orange,
N. J.; Consultant in Pediatric Roentgenology, The
New York Hospital, New York City. Second edition.
Chicago: The Year Book Publishers, Inc., 1950. Price,
\$22.50.

Chemistry Visualized and Applied. By Armand Jo-
seph Courchaine, Instructor in Biological Chemistry,
Hahnemann Medical College, and Science Instructor,
Hahnemann Hospital School of Nursing, Philadelphia.
Formerly Laboratory Supervisor, Human Serum Al-
bumin Department, Sharp & Dohme, Inc., Glenolden.

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GYNECOLOGY—Intensive Course, two weeks, starting February 19. Vaginal Approach to Pelvic Surgery, one week, starting March 5.

OBSTETRICS—Intensive Course, two weeks, starting March 5.

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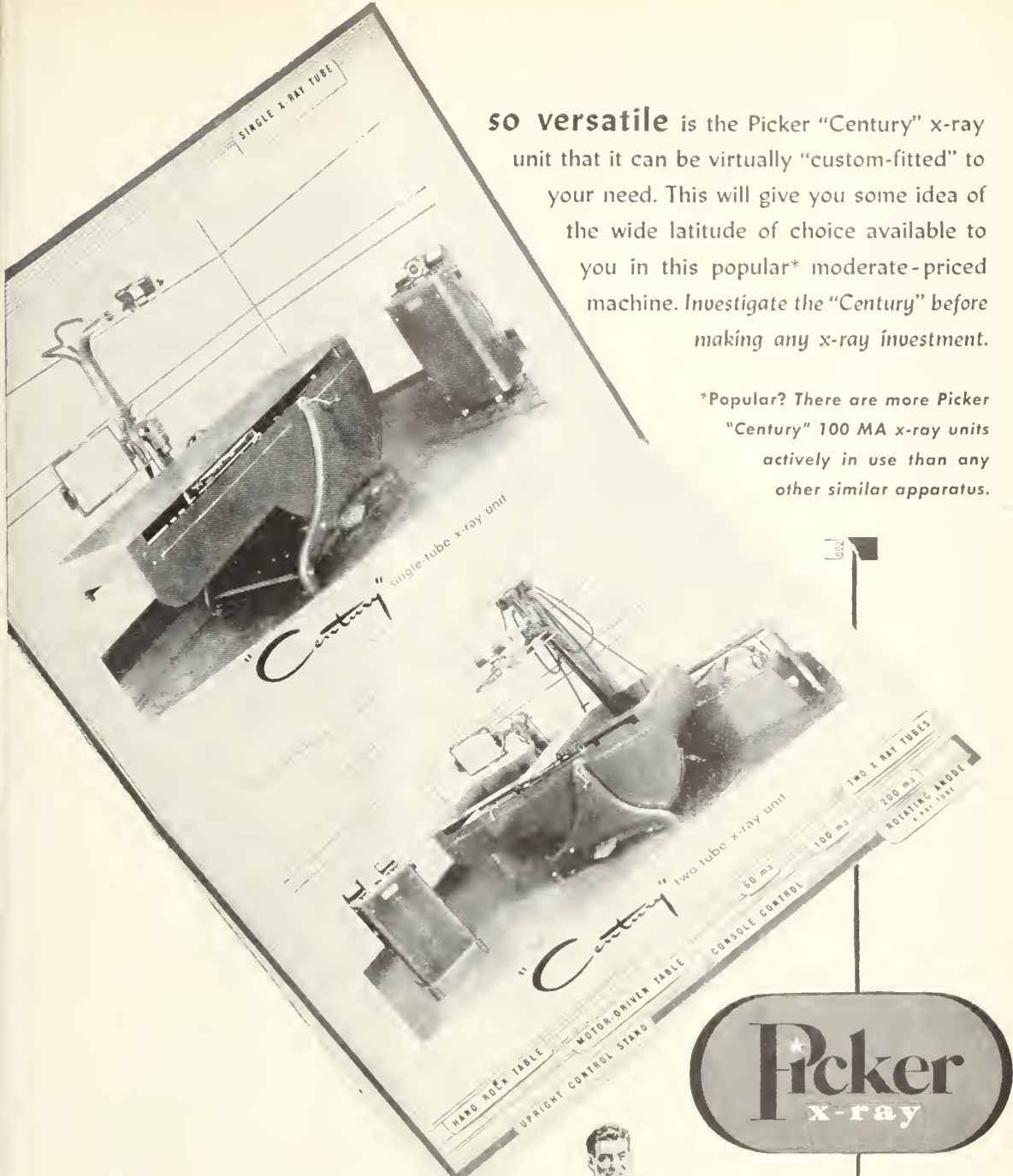
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and Chemical Analyst, Allied Chemical & Dye Corporation, Barrett Division, Philadelphia. Edited by M. Cordelia Cowan. Drawings by Richard Albany. New York: G. P. Putnam's Sons, 1950. Price, \$5.50.

Principles of General Psychopathology. An interpretation of the theoretic foundations of psychopathologic concepts. By Siegfried Fischer, M.D., Clinical Instructor in Psychiatry, University of California; formerly Professor of Psychiatry and Neurology, University of Breslau. New York: Philosophical Library, 1950. Price, \$4.75.

Emergencies in Medical Practice. Edited by C. Allan Birch, M.D., F.R.C.P., Physician, Chase Farm Hospital, Enfield. With 131 illustrations, 8 in full color. Second edition. Baltimore: The Williams & Wilkins Company, 1950. Price, \$5.50.

Differential Diagnosis of Internal Diseases. Clinical Analysis and Synthesis of Symptoms and Signs. By Julius Bauer, M.D., F.A.C.P., Clinical Professor of Medicine, College of Medical Evangelists, Los Angeles: Senior Attending Physician, Los Angeles County General Hospital; Consultant in Medicine, White Memorial Hospital, Long Beach Veterans Administration Hospital, and Cedars of Lebanon Hospital, Los Angeles; formerly Professor of Medicine, University of Vienna. New York: Grune & Stratton, 1950. Price, \$12.00.

Broncho-esophagology. By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Broncho-esophagology and Laryngeal Surgery, Temple University, Philadelphia, and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., Professor of Broncho-esophagology and Laryngeal Surgery, Temple University, Philadelphia. Illustrated. Philadelphia: W. B. Saunders Company, 1950. Price, \$12.50.

Regional Orthopedic Surgery. By Paul C. Colonna, M.D., Professor of Orthopedic Surgery, University of Pennsylvania Medical School. Philadelphia: W. B. Saunders Company, 1950. Price, \$11.50.

Current Trends in the Relation of Psychology to Medicine. By Wayne Dennis, Robert H. Felix, Carlyle Jacobsen, Robert A. Patton, Yale D. Koskoff, Paul E. Huston, Nathan W. Shock, and Hans J. Eysenick. Eight lectures under the auspices of the Department of Psychology in the College of the University of Pittsburgh delivered during February 9 and 10, 1950, in the Stephen Collins Foster Memorial. Pittsburgh: University of Pittsburgh Press, 1950. Price, \$3.75.

Physicians' Federal Income Tax Guide and Simplified Accounting Record. 1951 edition. For the preparation of 1950 returns and 1951 estimates. By Hugh J. Campbell and James B. Liberman. Great Neck, N. Y.: Doniger & Raughley, Inc., 1950. Price, \$2.50.

The Other Side of the Bottle. By Dwight Anderson. With Page Cooper. New York: A. A. Wyn, Inc., 1950. Price, \$3.00.

ACTH AND CORTISONE REDUCE CANCER PAIN

Evidence gained in a study of far-advanced cancer patients by three Chicago doctors indicates that treatment with ACTH and cortisone is helpful in reducing the pain and other complications of the disease but does not materially alter the natural course of the disease.

Drs. Samuel G. Taylor, III, John P. Ayer, and Roger S. Morris, Jr., reported on their study of 26 advanced cancer patients in the November 25 *Journal of the American Medical Association*. All three doctors are associated with the Presbyterian Hospital, Chicago.

The report says in part:

"The clinical response of most patients was reduction in fever, if present, increased appetite, and improved strength and well-being. At times the effects were dramatic and appeared usually within 48 hours after ACTH therapy and within four to six days after starting treatment with cortisone.

"Patients hitherto bedridden, vomiting, and requiring heavy doses of narcotics were able to become ambulatory, reduce or stop their reliance on narcotics, and eat astonishing meals."

According to the report, however, the "improved" condition of the patients was only temporary. The natural course of the disease continued—12 of the patients already have died. In addition, the hormone treatment produced disturbing side effects.

"We have frequently been faced with the problem," the doctors explained, "whether complications produced by continued therapy or relapse from omission caused more distress to the patient."

Some of the side effects produced by ACTH and cortisone which, according to the doctors, may make "repeated or prolonged therapy ill advised" were chemical changes in the body, excess sugar in the blood, mental and personality changes, sexual and skin disturbances, development of moon-shaped faces and unnatural fat deposits in different parts of the body.

RURAL HEALTH CONFERENCE TO BE HELD IN MEMPHIS

The sixth annual National Conference on Rural Health will be held in Memphis, February 23-24. It will be sponsored by the Committee on Rural Health of the American Medical Association in cooperation with national farm organizations. The Medical Society of the State of Pennsylvania will be represented by Dr. C. L. Palmer.

More than 700 farm and health leaders, including representatives of health and farm groups, farm newspapers, agricultural extension organizations, rural health committees, schools, public health officials and others, are expected to attend. Sessions will be held in the Peabody Hotel.

The theme will be "Why Wait—Let's Do It Ourselves," according to Dr. F. S. Crockett of Lafayette, Ind., chairman of the committee, who made the announcement. Dr. Crockett will outline the national rural health program.

State rural health committee chairmen will hold a preliminary meeting on February 22, the day before the conference opens.

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1. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 5th ed., 1946, 704-705

2. Beckman, H.: Treatment in General Practice Philadelphia, Saunders, 6th ed., 1948, 744

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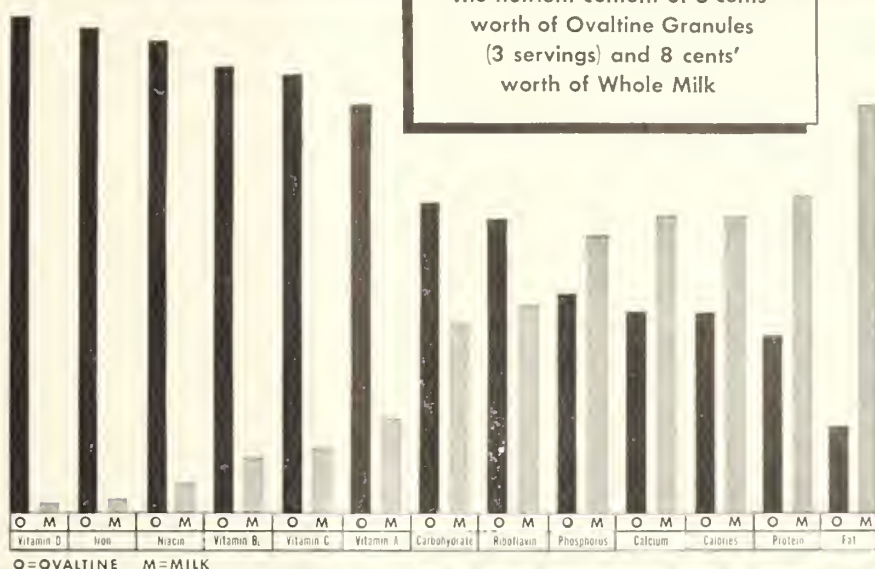
Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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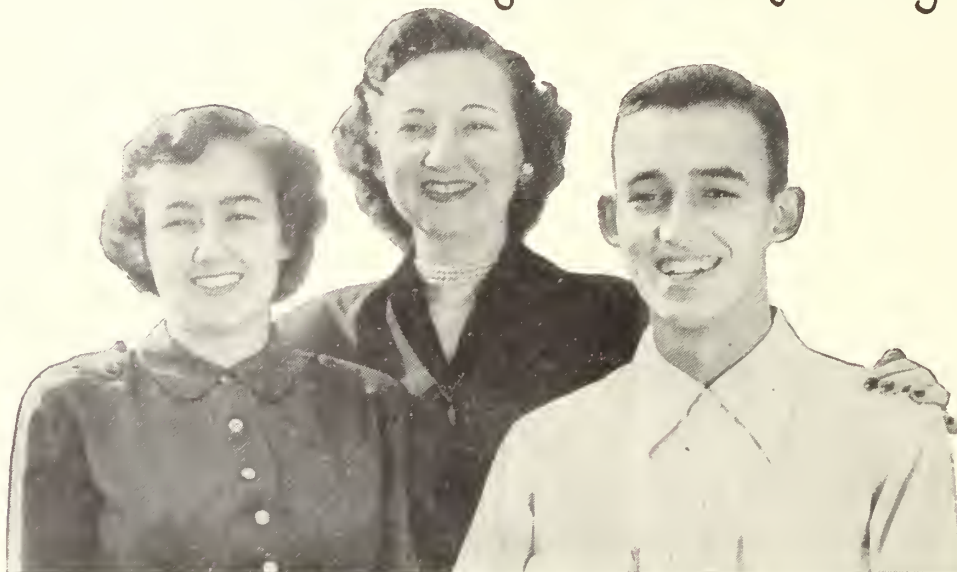
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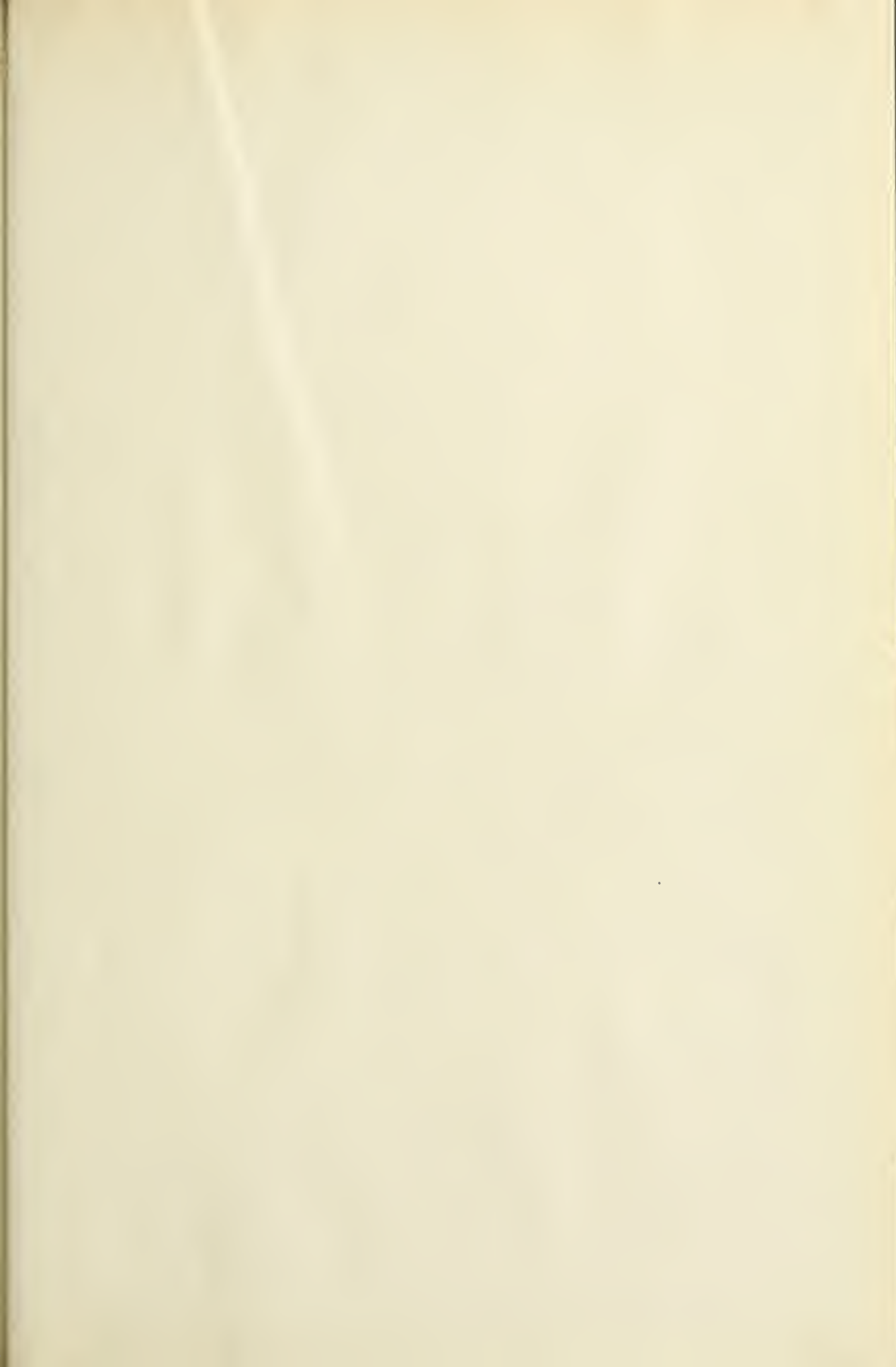
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